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ATTACHMENTS

ATTACHMENT 1

THE VISION, MISSION, AND GUIDING PRINCIPLES FOR THE MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE DEMONSTRATIONS

Vision Statement

All persons in need of mental health and substance abuse services across Wisconsin have equal access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, quality of life and dignity.

Mission Statement

The mission of the mental health and substance abuse systems throughout Wisconsin is to achieve the vision by:

1. Creating partnerships that develop, coordinate and provide a full range of resources that address:

    - risk reduction/prevention
    - wellness
    - early identification and intervention, treatment and
    - rehabilitation options
    - recovery
    - safe and affordable housing
    - educational, employment, social and recreational opportunities
    - family and peer support
    - self-help services
    - safety and well-being of all members of the community

2. Emphasizing hope and optimism in all interactions.

3. Implementing a comprehensive strategy to eradicate stigma and discrimination.

4. Involving consumers/families/communities as equal stakeholders in service system governance, planning and delivery.

5. Acknowledging the abundance and limitation of our human and financial resources and committing to responsible stewardship of these resources.

Guiding Principles

The Blue Ribbon Commission developed the following guiding principles to guide funding, policy, and program development in the future mental health and substance abuse systems.

- All partners of the mental health and substance abuse systems are accountable for positive outcomes.

- Families of children and adolescents involved in the mental health and substance abuse systems are recognized as central partners in the treatment process.

- The mental health and substance abuse systems respond to the special needs of underserved populations.

- Meaningful participation of consumers, their families, and advocates is critical to successful system design and implementation.

- The mental health and substance abuse systems recognize each individual's dignity, right to self determination, and right to effective treatment approaches that promote recovery and hope and are based on the expressed preferences of the consumer and the best interests and well-being of the community.

- The mental health and substance abuse systems are accountable for efficient and effective use of available federal, state, county, and private financial resources.

- Flexible funding fosters development of highly individualized service/treatment plans that build on consumer, family, and community strengths and enable individuals and families to meet their needs, hopes, and desires.

- Treatment and other services are cost effective and efficiently use all available resources, including natural supports, to achieve positive consumer outcomes.

- Services emphasize preventive interventions, risk reduction, and early identification.

- High quality mental health and substance abuse services are available to persons throughout the State regardless of geographic location, age, degree of disability, or availability of personal financial resources.

- Services focused on successful living in communities provide access to jobs, housing, and transportation as well as health, educational, vocational, social, spiritual, and recreational resources. They make full use of natural supports.

- The mental health and substance abuse systems take a flexible, creative, and at times non-traditional approach to providing services. Services are comprehensive, culturally relevant, and within available resources make every effort to meet the needs of consumers, families, and communities.

- Consumers are empowered to take more control of their lives and are given the resources and skills to be responsible for their actions and decisions.

- Service providers are competent and provide high quality, culturally relevant mental health and substance abuse treatment, rehabilitation, and support services. Personal experience with psychiatric or emotional disorder and/or substance abuse recovery is valued in the employment setting.

- Efforts to change negative public attitudes and their resulting behaviors, such as discrimination, are in place in local communities and at the state level.

The mental health and substance abuse systems collaborate in the formation of sound social and health policies and practices that prevent mental health and substance problems.

ATTACHMENT 2

Blue Ribbon Commission Target Populations

Target Group 1. Persons in Need of Ongoing, High-Intensive, Comprehensive Services

Persons in need of ongoing, high-intensive, comprehensive services have a primary diagnosis of a major mental illness or severe emotional disturbance and they have substantial needs in areas such as psychiatric and medical treatment, including substance abuse, daily living skills, budgeting, job training, family support and psychotherapy. Some of these persons may also have a history of trauma, such as physical or sexual abuse or neglect, that may contribute to the mental health problem. Persons in this category may need help to access resources in the community such as safe, afford able housing, benefits and entitlement and legal assistance. They need support and assistance in combating stigma and discrimination. Without ongoing comprehensive services, these individuals will be at the highest risk for increased psychiatric hospitalizations, or extensive reliance on out-of-home placement in nursing homes, child caring institutions, and other supervised settings, confinement in jail, homelessness, and increased harm to self.

Due to increases in the symptoms of mental illness or environmental stresses, these persons will sometimes experience acute psychiatric crises. Some of these persons may be reluctant to access mental health or other services, and extensive outreach and relationship development may be needed to engage them into services. Ongoing comprehensive treatment and intensive community support and wraparound services are needed to assist the person and family to achieve and maintain a more stable level of functioning and a lifestyle that is more reliant on natural supports and less dependent on the formal mental health services.

Target Group 2. Persons in Need of Ongoing, Low-Intensive, Comprehensive Services

Persons in need of ongoing, low-intensive, comprehensive services have a diagnosed mental health disorder and function in a fairly stable manner but occasionally may experience acute psychiatric crises. Some of these persons may also have a history of trauma, such as physical or sexual abuse or neglect, that may contribute to the mental health problem. These persons need services such as ongoing medication management (prescription, evaluation and monitoring), case management and/or periodic support contacts. With the benefit of such services, they are usually able to live relatively independently and have good potential for recovery and increasing success in community living. Without ongoing supports and services, however, they can be at a serious risk for relapse and for much more costly treatment including intensive crisis intervention and psychiatric hospitalizations.

This group also includes persons who are at the early onset of their mental disorder or emotional/behavioral disorder. With early identification and appropriate treatment interventions, these persons may be able to maintain stable functioning in the community and avoid the dependence and chronicity caused by long-term institutional or residential care. Appropriate identification of mental health problems for this target group is critical, especially because they often are first seen in non-mental health settings, i.e., primary care sector, school system, law enforcement, etc.

Target Group 3. Persons Needing Short-Term Situational Services

These persons experience situational crises such as divorce, death of parent, spouse or significant other, or severe trauma such as sexual abuse, physical abuse, or neglect that may contribute to a mental health problem. They require short-term support, treatment, or counseling services. Due to the situational difficulties, these persons may experience temporary difficulties in their vocational, educational, family or social roles. These persons may experience acute psychiatric crises that endanger themselves or others. Without appropriate and early identification and diagnosis, short-term counseling, and treatment, the person's mental status and role functioning may be at risk of further deterioration. Appropriate identification of mental health problems in this population is critical because they are often first seen in non-mental health settings, i.e., primary care sector, school system, aging services, law enforcement, etc.

Target Groups in Need of Prevention and Early Intervention Services

Target Group 4. Persons at Risk

These persons live in circumstances and environments that may increase their risk to develop mental health problems at some point in their lives, i.e., poverty, physical/sexual abuse, neglect, drug abuse, family violence, etc. Young children in this target group exhibit behaviors that bring them to the attention of parents, teachers, law enforcement personnel and require intervention to prevent the behavior from becoming more disruptive. Adults in this target group exhibit behavior and symptoms which do not meet the criteria for diagnosis of a mental disorder, but experience significant emotional distress following loss of a job, spouse, child, parent, etc. Older adults in this target group also experience emotional distress following elder abuse and neglect, significant interpersonal losses, etc. These persons require prevention and early intervention services to maintain their emotional well being and their level of functioning in community life.

Target Group 5. Persons at Acceptable Level of Mental Health

These persons experience satisfaction and emotional stability in their lives. These persons have the coping skills, natural support networks, and other resources to cope with stresses in their life and meet their major life goals. These persons require efforts to maintain their mental well being through wellness promotion and disease prevention efforts.

ATTACHMENT 3

Consumer Rights and Responsibilities

Preamble/General Principles

The Governor's Blue Ribbon Commission (BRC) on Mental Health, Final Report's Guiding Principles provided a foundation for this report. This report applies to all consumers in a Managed Care Organization, except for highlighted items. The following issues are not statements of rights per se, but definitions, clarifications, or details of how to implement issues related to a consumer's rights. These details pertain to all statements of rights listed below.

- Definitions:

  - Legal Representative – For the purposes of this paper, a legal representative is the consumer's legal guardian per ch. 880, Wis. Stats., health care agent per ch. 155, Wis. Stats., or the parent of a minor child.

  - Grievance – The process for addressing disputes between a consumer and a service provider described in HFS 94. This document proposes to use this process for disputes between a consumer and a MCO.

  - Contractual Complaints – The process through which a consumer or the consumer's legal representative lodges an objection with a representative regarding a determination, an act or failure to act of the MCO with the Department's contract monitor(s). A contract monitor may provide technical assistance to the consumer and the MCO, require the MCO to comply with contractual provisions, or impose a fine or penalty against the MCO as may be provided in the contract.

  - Regulatory Complaint – The process through which a consumer or the consumer's legal representative lodges an objection with a representative regarding a determination, an act or failure to act of the MCO with the Bureau of Quality Assurance (BQA) or the Department of Regulation and Licensing (DRL). This process will not apply to disputes between a consumer and a MCO, but may apply to disputes between a consumer and a service provider or individual professional. Upon receipt of a complaint, BQA or DRL will conduct an investigation to determine if the service provider or individual professional has complied with applicable statutes and regulations. If BQA or DRL determines that a violation of statute or regulation has occurred, enforcement action against the service provider or individual professional will be taken, as provided by applicable statutes and regulations.

- Fair Hearing – The quasi-judicial process required by federal regulations at 42 CFR 431.200 through 431.250 and similar provisions in State statutes. The Division of Hearings and Appeals is responsible for administration of fair hearings for the Department.

♦ Some guiding principles:

- The MCO and providers need to use a collaborative ethic when working with consumers, service providers, and service provider staff. All consumers must be treated with respect and dignity and as individuals.

- The MCO and providers need to identify and build upon a consumer's strengths and abilities.

- The MCO and providers must focus on the steps forward that a consumer makes and to display a belief that recovery is obtainable for each consumer.

- The MCO and providers must recognize that learning is a two-way street between the MCO/provider and consumer.

- The consumer is the expert regarding how the illness affects him or her and on his or her strengths, needs and goals.

♦ Issues:

- The time limit for filing a contractual complaint, grievance, or request for fair hearing should be 45 days from the date of the incident or from the date of the person's ability to understand that a potential violation of their rights may have occurred or the legal representative's discovery of a potential violation of the consumer's rights, whichever comes later.

- A consumer may choose to have an advocate of his/her choice to assist in any of the processes for lodging a protest or objection against a MCO for an act or failure to act that may involve a denial or limitation of a right listed below. An advocate is a person who can assist in articulating the consumer's preferences and decisions. An advocate may be a family member, a friend, a neighbor, a staff person from an advocacy agency (e.g., the Wisconsin Coalition for Advocacy), Board on Aging Ombudsman, etc.

- It is essential that all parties understand the ongoing relationship between the consumer and the MCO. It may be anticipated that issues involving a consumer's rights are more likely to occur during the initial months as the MCO does not yet know the consumer's strengths, needs and preferences and the consumer does not yet know the MCO staff or the MCO system of care. However, issues involving a consumer's rights may arise at any time in this relationship due to the fact that the consumer's strengths, needs and preferences may change over time. Each interaction between MCO staff and a consumer (not limited to assessment and reassessment of the consumer and a MCO decision to act or not to act) provides the opportunity to uphold or violate the consumer's rights and responsibilities.

- The statements of rights and consumer responsibilities listed in this document only pertain to the relationship between a consumer and the MCO and any entity or provider with which the MCO subcontracts. A consumer does have rights, under s. 51.61, Wis. Stats., and HFS 94 that service providers must meet and may have additional rights under State or federal statutes or regulations applicable to a type of service provider (e.g., Community Support Program, inpatient psychiatric hospital, nursing home, etc.)

- Consumers should attempt to informally resolve any dispute with the MCO and its staff. It is hoped that most disputes will be able to be resolved in this way. There is no requirement to file a contractual complaint, grievance or request for a fair hearing or exhaust any of these procedures before proceeding to another. However, consumers are encouraged to attempt to resolve disputes as close to their source as possible. The MCO should utilize several mechanisms, such as an ethics committee reviews, consumer satisfaction surveys, and internal administrative reviews to help resolve, and to the extent possible prevent, disputes between the MCO and consumers. In addition, the Department should assist MCOs to develop regional mediation services that MCOs and consumers could use to informally resolve disputes.

♦ State Fair Hearing Processes:

- Consumers have a right to contest any of the following applicable matters by filing, within 45 days after receipt of notice of the contested matter, a written request for an administrative hearing that shall be held under procedures for hearing these disputes that are prescribed by the Department by rule:

  1. Denial of eligibility for capitated payments

  2. Determination of cost sharing

  3. Denial of entitlement

  4. Failure to provide timely services or supports that are included in the treatment and recovery plan.

  5. Development of a treatment and recovery plan that is unacceptable because the treatment and recovery plan provides treatment, services or supports that are insufficient to meet the consumer's needs, are unnecessarily restrictive or are unwanted by the consumer.

  6. Termination of capitated payment and the resulting benefits if the consumer is enrolled to receive capitated payments.

     - Upon receipt of a request for fair hearing, the Division of Hearings and Appeals should notify the MCO and the Department of Health and Family Services contract monitor, who should be responsible to informally reconsider the determination causing the dispute

between the MCO and the consumer in an attempt to resolve the dispute prior to the actual hearing date.

- The Division of Hearings and Appeals may consolidate multiple hearing requests filed by an individual if the contested matters are related to one another.

- Note: 42 CFR 431.231 requires a Medicaid recipient to file the written request for an administrative hearing within 10 days after receipt of notice of the contested matter in order for Medicaid payment to continue during the appeal process.

Statement of Right Contract Complaint (C), Regulatory Complaint (R), Grievance (G), or Fair Hearing (F)			**Investigate/ Enforce**
1.	To seek help from the MH/AODA system, including:		
	a)	To be referred to or otherwise apply for services through the MH/AODA system.	C
	b)	To receive or to be referred appropriately for services immediately if there is risk to your health and safety or that of others.	C
	c)	To receive a prompt determination of whether you are functionally and financially eligible for MH/AODA capitated payments and to a state fair hearing if you are not determined eligible or disagree with the level of eligibility determined.	C, G or F
	d)	To receive a determination indicating if you are functionally and financially eligible for the non-capitated priority population (this provision only applies to persons who are seeking to enrollment for capitated payments).	C or G
2.	To receive information and education you need in order to make informed choices about receiving MH/AODA services either through MH/AODA capitated payments or the fee-for-service systems provided in a form that:		
	a)	Is most understandable to you and is presented at a time when you can understand the information.	C or G
	b)	Is culturally and gender appropriate.	C or G
	c)	Fosters your ability to speak for yourself in identifying choices, understanding and exercising rights and responsibilities, and voicing complaints. Specifically, you have the right to be fully informed at the time of enrollment and periodically about the procedures for filing a contractual complaint, grievance, or fair hearing, as applicable, concerning a violation of any right noted in this document or violation of a right provided under ss. 51.30 or 51.61, Wis. Stats., HFS 92 or 94, or other statute or regulation applicable for a specific provider of treatments or services.	C or G

Statement of Right Contract Complaint (C), Regulatory Complaint (R), Grievance (G), or Fair Hearing (F)	Investigate/ Enforce
d) Provides information (including information about your financial responsibility for the cost of your services), assistance and/or referral for other services that might be appropriate and available even if you are not eligible for services through MH/AODA capitated payments.	C or G
3. To participate in planning and evaluating MH/AODA services, including:	
a) Fully participating in assessing your strengths, needs and preferences.	C or G
b) Planning and evaluating your own treatment and services, and the broader service delivery systems at both the local and statewide levels.	C or G
c) Choosing any other people you want to participate in planning your services.	C or G
d) Having care plan decisions arrived at using objective criteria defined in the MCO contract and MCO policies and procedures. The MCO authorizes, modifies or denies care plan decisions using criteria stated in the MCO contract, and publicly available policies and procedures. If the MCO modifies or denies a care plan decision, the MCO must provide a due process notice informing the consumer of his/her right to file a contractual complaint, grievance, or request for a fair hearing, as applicable.	C or G
e) Having care plan decisions based on your strengths, needs, abilities, goals and preferences.	C or G
4. To receive a "second consultation" assessment and have the MCO pay for this subject to criteria developed by the DHFS.	C or G
5. If eligible, to choose whether to participate in managed care, and to disenroll from capitated managed care for any reason. If you receive capitated funding, you have the right not to be disenrolled from the capitated funding due to treatment refusal; request to change treatment professionals or providers; diagnosis; changes in health status; cost of treatment; participation in a contractual complaint, grievance, or fair hearing process; or other factors which do not constitute just cause for disenrollment.	C or G
6. To choose from among services and providers, including the right to choose:	C or G
a) From among the treatment professionals or providers within the MCO network, and to request the addition of providers to the network.	C or G

Statement of Right Contract Complaint (C), Regulatory Complaint (R), Grievance (G), or Fair Hearing (F)	Investigate/ Enforce
b) Providers outside the MCO network if it does not have providers with the specialized knowledge needed to treat your condition or meet your specific needs.	C or G
c) A self-directed care option, as defined by the Department (this provision only applies to persons receiving capitated payments and only when such an option has been fully develop, approved and incorporated into the managed care contracts).	C or G
d) Providers who are accessible in terms of distance and times available.	C or G
7. To receive the treatments and services you need when you need them, including:	
a) An individualized assessment to determine your strengths, needs and preferences.	C or G
b) Development of a treatment and recovery plan tailored to meet your unique needs, circumstances and preferences as discovered through the assessment, including a crisis plan that details how you want to be treated when you experience a crisis.	C or G
c) A treatment and recovery plan that is current, is modified as necessary and includes meaningful, measurable goals for you.	C or G
d) To receive treatments and services and supports from qualified providers that are prompt, adequate and appropriate for meeting your individual needs, and that promote treatment and recovery and that as much as possible keeps you free from abuse, neglect and financial exploitation.	C or G
e) The right to access the most appropriate and effective medications as prescribed by a physician, which are on a formulary that is no more restrictive than the drug formulary used by the Medical Assistance program.	C or G
8. To accuracy and confidentiality of, and to have access to, information about you, as provided by State and federal laws and regulations.	
9. To personal autonomy and other civil and legal rights, including being able to:	
a) Make your own choices and decisions to the extent that you are able, and to be supported to make decisions that maximizes your ability and autonomy and recovery.	C or G
b) Receive treatment/services in the least restrictive conditions consistent with your treatment and recovery plan.	C or G

Statement of Right Contract Complaint (C), Regulatory Complaint (R), Grievance (G), or Fair Hearing (F)	Investigate/ Enforce
c) Live in the setting you choose consistent with your treatment and recovery plan.	C or G
d) Fully exercise your rights as a MCO member and any other civil and legal rights to which you are entitled.	C or G
e) Give informed consent for treatment and services provided by the MCO or any entity or provider with which the MCO subcontracts.	C or G
10. To dignity, respect, and fair and equitable treatment, and to be free from stigma and discrimination.	C or G
11. To assistance in understanding your rights and resolving disputes, including assistance from:	
a) Your care manager and other service providers, as applicable.	C or G
b) An internal consumer advocate in each MCO.	C or G
c) An external advocate secured by the state and not associated with the MCO, or other provider of direct services.	C or G
12. To fair and equitable due process procedures for resolving complaints or disputes, including:	
a) The opportunity to resolve disputes informally with individual service providers, case managers, or other employees of service provider organizations or MCOs.	C or G
b) Access to a more formal procedures to resolve disputes.	C or G
c) Resolution of any complaint you raise within time periods required by statute, regulations, or contract language.	C or G
d) The right to bring a court action at any time against any person or organization, including the state or any political subdivision thereof, for violation of your rights.	C or G
e) To be guaranteed that any utilization or other review of your treatment and services shall involve a professional having the training, credentials, and licensure required to provide treatment in the State of Wisconsin, and having no direct financial interest in the decision.	C or G
f) To be represented by any advocate, peer or other representative you choose at any level of review and resolution of disputes, and to receive information about the availability of independent advocacy services, and other local consumer advocacy organizations and support groups that might assist you in the complaint process.	C or G
g) To be free from reprisal or the overt or implied threat of reprisal.	C or G

Consumers Responsibilities

It is important that consumers understand not only their rights, but also their responsibilities. The work group recommends that the state develop standards for a MCO member handbook that is given to each member upon enrollment. That handbook should delineate the members' rights as well as the following responsibilities:

- To provide full, correct and truthful information, to the extent possible, requested by providers to determine eligibility, cost sharing, or to meet their fiscal and data reporting requirements.

- To allow the release of records as needed for the development of the treatment and recovery plan, coordination of treatments and services, and for funding related to your treatments and services.

- To participate in the initial and ongoing assessment, development, implementation, and review of your treatment and recovery plan.

- To use any benefits you are entitled to under other programs or private insurance to pay for services before these expenses are charged to the MCO.

- To use MCO providers, if you are enrolled to receive capitated funding, unless you and the MCO mutually agree otherwise.

- To pay the cost-share that you are required to pay, if any, toward the services you receive.

- To assist in the development of a crisis plan and following your crisis plan when necessary.

- To participate in quality assurance processes (e.g., consumer satisfaction surveys, focus groups, etc.) that will help the MCO improve treatments and services.

- To report in a timely manner any changes in your personal health, household or financial status which might affect eligibility or the amount of benefits or services received.

- To understand that one has the responsibility to strive towards recovery.

- To make good faith efforts to achieve the goals of one's service plan.

- To take calculated risks to move forward on one's path to recovery.

- To recognize that one's recovery process begins with oneself.

- To speak up and ask questions on any matter that is important to one's recovery.

ATTACHMENT 4

MENTAL HEALTH/SUBSTANCE ABUSE MANAGED CARE ADVISORY COMMITTEE

Updated February 1999
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January 1999

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ATTACHMENT 5
MH/AODA Managed Care Initiative Flow Chart
Flow Chart – March 1999

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ATTACHMENT 6

County/Tribal Planning Partners

Overview of MH/AODA Managed Care Proposals

Proposals For Integrated MH/AODA and Primary and Acute Care

Proposer	Key Organizational Features
Dane	County administered; contract for services; talking with Unity re: medical.
Milwaukee	Contract for administration and services.
Northwoods (North-Central/F/V/O)	County administered; contract for some services; talking with HMOs and tribes.
Outagamie/Oneida Nation	County will administer and provide some services; talking with United Health and Network re: medical.
Marinette/Florence/Oconto	County will administer and provide services; want to explore county self-insurance plan for medical.

Proposals for MH/AODA Only

Proposer	Key Organizational Features
Waukesha	County administered and contract for some services
Brown	County administered and provide most services
Fond du Lac	County administered and provide most services
Kenosha	County administered and contract for most services
Northern Pines	County administered and provide most services

Shaded sites sent a full team of county staff, consumers, family members and key providers to planning groups. Other sites were invited to send one representative to each planning group.

ATTACHMENT 7

Phase-In of Requirements for Demonstration Sites

The following table describes how counties/tribe will phase in the requirements described in this RFC.

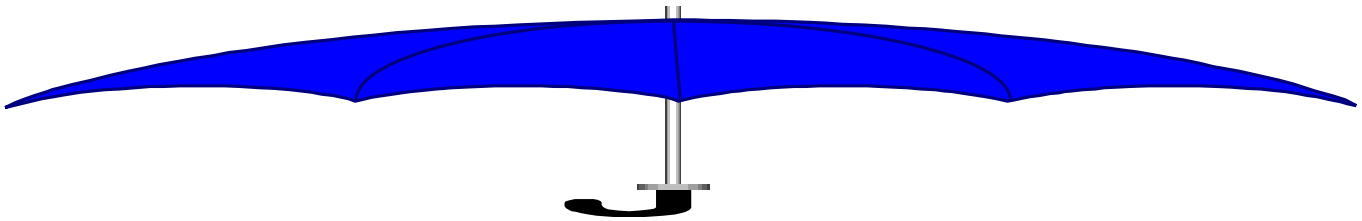
The first section "Required under initial period prior to capitation" describes those requirements that must be implemented in full or in part during the period between the time the county/tribe receives initial start-up funding and the time they begin to enroll consumers into prepaid, capitated managed care. Some of these are required because they apply to all providers (e.g., use of Uniform Placement Criteria for AODA are part of new DHFS standards, HIPAA requirements apply, to the degree they are currently implemented, to all providers). Others are required in order to develop the infrastructure needed to move towards capitated managed care (e.g., consumers and families in governance structure, development of management information system).

Those requirements identified in the second section, "Proposers would describe how they would phase these in," *may* be implemented *prior* to enrollment of consumers into prepaid, capitated managed care, but *must* be implemented once the county/tribe begins to enroll consumers into prepaid, capitated managed care. Proposers should describe their timetable for implementing these requirements in their workplan.

The requirements in the last section will not be implemented until the point when consumers enroll in prepaid, capitated managed care.

RFC Section	Requirement
Required under initial period prior to capitation	
III. D. 5. K	Use Uniform Placement Criteria for AODA
III. E. 1	Consumers/Family Members in Governance Structure
III. E. 2	Consumer/Family Role on QI Committee
III. F. 3	Implement strategies for recovery
III. F. 5	Recovery training
III. G. 5	Initial requirements for developing QI structure
III. H. 2. A	Develop and maintain database of service utilization and expenditures
III. H. 2. B	Meet HIPAA requirements
V. A. 5	Complete screen for interested individuals
V. A. 5	Identify County/Tribal share

RFC Section	Requirement
Proposers would describe how they would phase these in	
III. C	Enhance the front end of the system
III. D. 3. A	Provide with service coordinator
III. D. 3. B	Comprehensive Assessment and POC within 60 days
III. D. 3. c. (1)	Consumer/Family participation in decision-making
III. D. 3. c. (2)	Choice of providers
III. D. 3. c. (3)	Choice of living arrangements
III. D. 3. c. (5)	Informed choices—increased information
III. D. 3. c. (6)	Second Consultations
III. D. 4	Treatment and Recovery Team and Plan Of Care
III. D. 5. J	24/7 emergency services using Medicaid-certified crisis program.
III. D. 5. L	Improve integration of services for persons with co-occurring MH and AODA
III. E. 3	Consumer Affairs functions
III. E. 4	Other consumer and family requirements, e.g., contract with CST, as part of hiring process, hire consumers and family members
III. F. 1	All services promote consumer autonomy
III. F. 4	Encouraged to contract with consumer-operated programs
III. H. 2. D	Record and report performance indicators
Would not be implemented until capitation begins	
III. D. 5. a-f	Requirements for Category A, B and C services
III. D. 5. I	Enrollment limits
III. D. 5. N	Waive program standards
Attachment 3	Consumer Bill of Rights
III. G. 3	Practice Guidelines
III. H. 2. A	Have ability to conduct, or contract for, claims processing



ATTACHMENT 8

CARE MANAGEMENT ORGANIZATION

PROVIDES SERVICES TO ALL PERSONS IN THE CURRENT 51 SYSTEM* REGARDLESS OF MEDICAID ELIGIBILITY THROUGH 2 PAYMENT METHODS:

NON-CAPITATED	CAPITATED
PROPOSERS DESCRIBE ♦ Current Populations Served (AODA, MH) ♦ Integration with Capitated Services ♦ Enhancements to: ▪ Care Management ▪ QI Processes ▪ Performance Based Contracting ▪ Others ??	**DHFS DEFINES** ♦ Populations Included ▪ BRC # 1 and 2 ♦ BRC Outcomes ♦ Individualized Assessment ♦ Practices and Standards ♦ QI Procedures * Will also include Medicaid eligible persons meeting functional criteria who are not in 51 system.

REQUIREMENTS FOR ALL PERSONS

- ♦ Consumer and Family Involvement
- ♦ Recovery Oriented Care Delivery
- ♦ Utilization Data Collection
- ♦ Service Expenditures by Consumer

ATTACHMENT 9

Requirements for Different Groups Under The Umbrella Design

	Capitated		Non-Capitated	
	Medicaid	**Non-Medicaid**	**Medicaid**	**Non-Medicaid**
Enrollment	Voluntary for BRC target populations 1 and 2 eligible to enroll (including those with co-occurring AODA).		BRC target population 1 and 2 who choose not to enroll in capitated *if they meet county/tribal priority populations* (e.g., those populations currently served in county 51 system). Other individuals who meet county/ tribal priority population. Includes BRC target population 3 and all AODA populations.	
Payment	Medicaid capitation rate paid to MCO. County share payment representing cost of non-Medicaid services to Medicaid eligibles. Determined using criteria defined by DHFS. Other third party funds that may be available.	County share payment representing county cost for services to non-MA population. Determined using criteria defined by DHFS. Other third party funds that may be available.	Medicaid fee-for-service payments. Co-payments, where applicable. Consumer cost-share for non-Medicaid covered services. County funding, as determined by county. Other third party funds that may be available.	Consumer cost-share. County funding, as determined by county. Other third party funds that may be available.

Category A Services* = Medicaid-covered services.

Category B Services = Services recommended by BRC or UPC that are not otherwise Medicaid-covered.

Category C Services = Other services recommended by treatment and recovery team and approved by psychiatrist or psychologist.

Medically necessary = Medicaid-covered services recommended by treatment and recovery team and that meet Medicaid definition of medically necessary.

Clinically indicated = Other services recommended by treatment and recovery team.

	Capitated		**Non-Capitated**	
	Medicaid	**Non-Medicaid**	**Medicaid**	**Non-Medicaid**
Service Eligibility	Category A services are an entitlement when medically necessary. Access to Category B and C services may be limited by the MCO (the services are not an entitlement) but MCO must meet consumer's needs	Services must be clinically indicated. Access to Category A, B and C services may be limited but MCO must meet consumer's needs	Category A services are an entitlement. MCO not responsible for paying for services but responsible to help consumer access these. Consumer may need to access these services in private sector. Category B and C services limited by county/tribe's funding.	Category A, B and C services limited by county/tribe's funding.

* See Section III, D, 5 of the RFC for additional information about Category A, B and C services.

ATTACHMENT 10

Medicaid Eligibility Categories

MA Subprogram/Category	MED STAT	Description	CARES Category
Community Waivers	WA	CIP IA	MCW-A
	WB	CIP IB	MCW-B
	W2	CIP 2	MCW-E
	WC	CSLA	MCW-C
	WI	Brain Injury Waiver	MCB-I
	WP	WI Partnership Program	MCW-P
	WW	Cop Waiver	MCW-W
SSI Nursing Home	ZN	Zebley children – NH	Non-CARES
	9	NH/SSI, cat	non-CARES
	17	SSI, nh, blind, cat	non-CARES
	28	SSI, nh, disabled, cat	non-CARES
MA Institutions, Cat Ndy	7	503, nh	MI-C
Protected	DN	dac, nh	MI-D
	L2	wid/widowers I, cat, nh	MI-W
	L4	wid/widowers II, cat, nh	MI-T
MA Institutions, Cat Ndy	3	aged, nh	MI-S
	13	blind, nh	MI-S
	25	Disabled, nh	MI-S
	43	IMD, <21, cat, no $	MI-M
	47	IMD, <21, med, no $	MI-M
	49	AFDC-rel'd, NH, cat, no $	MI-A
	52	AFDC-rel'd, NH, med, no $	MI-A
MA Institutions, Med Ndy	6C	503, med ndy, nh	MI-C
Protected	6D	dac, med ndy, nh	MI-D
	L6	wid/widowers I, med ndy, nh	MI-W
	L8	wid/widowers II, med ndy, nh	MI-T
MA Institutions, Med Ndy	6	Aged	MI-S
	16	Blind	MI-S
	26	Disabled	MI-S

MA Subprogram/Category	MED STAT	Description	CARES Category
SSI	RC	SSI, disabled, cat, sanctioned	non-CARES
	RN	SSI, disabled, cat, non-compliant	non-CARES
	ZZ	Zebley children	non-CARES
	1	SSI, aged	non-CARES
	2	SSI, Aged, PI	non-CARES
	8	SSI, blind, cat ndy, FC	non-CARES
	11	SSI, blind, cat	non-CARES
	12	SSI, blind, cat, PI	non-CARES
	18	SSI, disabled, cat, FC	non-CARES
	19	SSI, cat, s1619(a) & (b)	non-CARES
	20	SSI, essential person	non-CARES
	21	SSI, disabled, cat	non-CARES
	24	SSI, cat, PI	non-CARES
Katie Beckett	30	SSI, sub adopt	non-CARES
Foster Care/Sub-Adoption	33	AFDC-rel'd FC	non-CARES
Protected MA	34	AFDC-rel'd, FC, GPR-only	non-CARES
	35	AFDC-rel'd institutionalized	non-CARES
	36	AFDC-rel'd, inst, GPR only	non-CARES
Sub-Adoption – Protected (cont)	37	Foster Home	non-CARES
	56	Sub Adopt, cat	non-CARES
Kinship Care – Protected MA	KC	Kinship Care, AFDC-rel'd, cat	pending
AFDC MA	31	AFDC regular	MA-R
	32	AFDC-U	MA-U
	65	Refugees-reg AF	MA-R
	UR	Refugees-AFDC-U	MA-U
	79	Cub/Haitian – reg	MA-R
	UH	Cub/Haitian – AU	MA-U
	WH	100 rule waiver	MA-U
	WN	Work Not Welfare, AFDC, $, Cat Ndy	MA-R
	WU	Work Not Welfare, AFDC-U, $, CN	MA-U
MA Extensions	E2	child support	ME-C
	X1	Earnings/hours	ME-I

MA Subprogram/Category	MED STAT	Description	CARES Category
	X2	$30+1/3 loss	ME-T
	X3	$30 loss	ME-D
	X4	$30 + 1/6	ME-S
MA Newborn, Cat Ndy	N1	Continuously elig newborn	MN
AFDC-related, Cat Ndy	38	cat/no AFDC, reg	MAO-R
	UA	cat/no AFDC, AU	MAO-U
	80	Cub/Haitian	MAO-R
	95	preg/intact fam	MAO-U
	M1	Migrant w/ MA from out of state	MAO-R
	A3	IRCA preg, reg	MAO-R
	A5	IRCA preg, AU	MAO-U
Healthy Start, Cat Ndy	A6	IRCA preg, HS	MHS-P
	PW	pw, 133%	MHS-P
	CC	kid, <6, 133%	MHS-C
	GC	kid, 9/30/83, 100%	MHS-N
	A7	IRCA preg, preg ext	ME-P
	E3	pw, pregnancy ext	ME-P
SSI-related, Cat Ndy, Protected	10	503, cat ndy	MP-C
	DC	Disabled adult child, cat	MP-D
	L1	wid/widowers I, cat	MP-W
	L3	wid/widowers II, cat	MP-T
	RC	Deemed-SSI, child, cat, no $	pending
SSI-related, Cat Ndy	4	Aged	MS
	14	Blind	MS
	22	Disabled	MS
Refugees, No DOH Funding	66	AFDC-rel'd, refugees	non-CARES
	68	AFDC, nh, refugees	non-CARES
	69	Refugees, nh	non-CARES
	85	AFDC, nh, cuban/haitian	non-CARES
	86	nh, cuban/haitian	non-CARES
	87	nh, cuban/haitian	non-CARES
Refugees, Occasional DOH	76	cuban kids, non-t19	non-CARES

MA Subprogram/Category	MED STAT	Description	CARES Category
Funding	77	c/h, no t-19	non-CARES
	82	c/h ent, non-t19	non-CARES
	83	nh, cuban/haitian	non-CARES
Refugees (continued)	88	Refugees, non-t19	non-CARES
	89	nh, non-t19, refugees	non-CARES
Other Cat Needy	AE	IRCA-alien; emergency service only	non-CARES
	A1	IRCA - ABD or under 18	non-CARES
	IC	IMD, on leave	non-CARES
	40	Colony, cat, $	non-CARES
	41	Colony, cat	non-CARES
	42	Colony, med	non-CARES
	44	AFDC/I, child inst, cat	non-CARES
	45	AFDC/F, foster, corr cat	non-CARES
	46	IMD, cat, SSI or AFDC $	non-CARES
	48	AFDC/NH, cat	non-CARES
	50	AFDC/NH, cat	non-CARES
	51	Foster Home/Corr, cat	non-CARES
	53	AFDC/F/NH, cat	non-CARES
	54	AFDC/F/NH, cat, no gpr	non-CARES
	55	FC/NH, cat	non-CARES
	57	Sub Adopt, cat	non-CARES
	58	Sub Adopt/NH, cat	non-CARES
	59	AFDC/F, nh, fc, cat	non-CARES
	60	Foster Home, cat	non-CARES
	61	Foster Home/Corr/NH, cat	non-CARES
	62	Foster/Corr/NH, cat, no $	non-CARES
	63	AFDC/I, cat, nh	non-CARES
	64	AFDC/I, cat, nh	non-CARES
	67	AFDC/I, Kid, nh, cat	non-CARES
	78	c/h ent, non-t19	non-CARES
	81	AFDC-rel'd, c/h	non-CARES
	84	nh, c/h	non-CARES

MA Subprogram/Category	MED STAT	Description	CARES Category
MA Newborn, Med Ndy	N2	CEN, med ndy	NN
AFDC-related, Med Ndy	39	med ndy, reg	NAO-R
	M2	Migrant w/ MA from out of state	NAO-R
Healthy Start, Med Ndy	A8	IRCA med ndy, pw ext	NE-P
	A4	ICRA, med ndy, HS preg	NHS-P
	CM	kid 2 to under 6, 155%	NHS-C
	PC	kid <2, 155%	NHS-C
	E4	preg, end of preg ext	NE-P
	P1	preg, 155%	NHS-P
SSI-related, Med Ndy	5C	503, med ndy	NP-C
Protected	5D	dac, med ndy	NP-D
	L5	wid/widowers I, med ndy	NP-W
	L7	wid/widowers II, med ndy	NP-T
	RN	Deemed-SSI, child, med, no $	pending
SSI-related, Med Ndy	5	Aged	NS
	15	Blind	NS
	23	Disabled	NS
MA Institutions, Med Ndy	IM	IMD, on leave, med ndy	non-CARES
AFDC-related, Med Ndy, Ded.	MD	afdc-rel, deductible	NAO-R
Healthy Start, Med Ndy, Ded.	CD	kid < 2, deductible	NHS-C
Healthy Start, MN, Ded. (Continued)	HD	kid 2-6, deductible	NHS-C
	PD	preg, deductible	NHS-P
AFDC-related, Med Ndy	A2	IRCA - ABD, under 18	non-CARES
SSI-related, Med Ndy, Ded.	AD	aged, deductible	NS
	BD	blind, deductible	NS
	DD	Disabled, deductible	NS
100% State Funded	70	RNIP/MA	non-CARES
	71	good faith	non-CARES
	72	good faith	non-CARES
	73	RNIP/NH	non-CARES
	SA	State subsidized adoption, cat ndy	non-CARES

MA Subprogram/Category	MED STAT	Description	CARES Category
	74	Dummy code	non-CARES
BadgerCare	GP	BadgerCare Adults, <100%	BC
	B1	BadgerCare Child, > 100% to 150%	BC
	B4	BadgerCare Adult, > 100% to 150%	BC
BadgerCare - Premium payers	B2	BadgerCare Child, > 150% to 185%	BC
	B5	BadgerCare Adult, > 150% to 185%	BC
BadgerCare - Premium payers	B3	BadgerCare Child, > 185% to 200%	BC
	B6	BadgerCare Adult, > 185% to 200%	BC
Limited Services Eligibility	PE	Presumptive Eligibility, preg., cat ndy	non-CARES
	P2	Presumptive Eligibility, preg., med ndy	non-CARES
	TR	Tuberculosis-related eligibility	pending
Work Not Welfare, Trans. MA	TM	AFDC rel'd. No $, Cat Ndy	MAO-R
QMB Only	QN	QMB only, nh	QMB-N
QMB Only	QR	QMB only, non-nh	QMB
SLMB Only	SB	SLMB only, < 120%	SLB
Qualified Buyin Ind. – Group 1	Q1	Qualified Individual, 120% - 135%	pending
QDWI	QW	QDWI	QDW-I
Qualified Buyin Ind. – Group 2	Q2	Qualified Individual, >135% - 175%	pending

ATTACHMENT 11

Functional Screen for Enrollment Into Capitated Managed Care

Automatic Eligibility for Enrollment in MH/AODA Managed Care Benefit:

Consumers who are receiving community-based services from providers of mental health services which are certified in accordance with s. HSS 63.08, Wis. Adm. Code, Community Support Programs for Chronically Mentally Ill Persons, or consumers who meet criteria for admission set forth in s. HSS 63.08, Wis. Adm. Code, Community Support Programs for Chronically Mentally Ill Persons, are automatically eligible for enrollment.

Or

- Children who are receiving community-based services (wraparound) from providers of Integrated Services Programs in accordance with s. HSS 46.56, Wis. Stats., *and* children who have been assessed and meet criteria for admission set forth in definition for Severe Emotional Disturbance (see SED Checklist) are automatically eligible for enrollment.

To be eligible for enrollment in the MH/AODA Managed Care Benefit the consumer must:

- Have a serious and/or persistent mental illness or serious emotional disturbance or substance abuse disorder that has resulted in substantial functional disability which interferes with one or more major life activities such as personal relationships, living arrangements or employment/school, and does not include a primary diagnosis of mental retardation, developmental or organic brain syndromes and dementias.

Or

- Consumers who are seriously but not persistently disabled (functional disability, i.e., those consumers in a first acute episode) will be eligible for enrollment in the MH/AODA managed care benefit.

Or

- Consumers who have a persistent disability that is not currently severe. In some cases this is due to the benefits derived from community-based treatment and support services, without which the disability would again become severe. Some consumers in this group require continued ongoing support and their relatively good level of functioning will not disqualify them from benefits or service priority of the MH/AODA managed care benefit.

And

Have a functional disability due to mental illness and/or substance abuse disorder that substantially interferes with stable community life, e.g., self-care or independent community living, interpersonal/social functioning, vocational/academic/homemaker role functioning (one or more is required).

An individual's independence, appropriateness, and effectiveness in performing these tasks, as well as their ability to initiate and participate in such activities independently of supervision and direction, are to be taken into account in assessing areas of functioning.

- **Functioning in community living skills that interferes with stable community life:** Activities such as cleaning, shopping, cooking, eating, taking public transportation, paying bills, maintaining a residence, grooming and hygiene, managing physical health, using telephones and directories, using a post office, etc.

  Describe functional deficit:_____

  _____

  _____

- **Interpersonal functioning that interferes with stable community life:** An individual's capacity to interact appropriately and communicate effectively with other persons. This refers broadly to the person's ability to get along with others in his/her family and in the community. Deficits in this area are manifested by a consistent lack of age appropriate behavior, decision-making, judgement which results in potential involvement or involvement in the criminal justice system or juvenile justice system. Deficits in this area are reflected in events such as a history of altercations, high risk or recent history of arrest or incarceration, evictions or firing; fear of strangers; avoidance of interpersonal relationships, and social isolation.

  Describe functional deficit:_____

  _____

  _____

- **Functioning in family that interferes with stable community life:** Impairment is manifested by a pattern of significantly disruptive behavior, disregard for safety and welfare of self and/or others and/or violence to siblings, children, parents, spouse and/or other family members.

  Describe functional deficit:_____

  _____

  _____

- **Functioning in work that interferes with stable community life:** Impairment is manifested by the inability to consistently meet work requirements to keep a job. Inability to conform to work schedule, relate satisfactorily to a work supervisor, hostile or other behavior unacceptable to the work place.

  Describe functional deficit:_____

  _____

  _____

- **Functioning in school that interferes with stable community life:** Impairment is manifested by the inability to pursue educational goals in a reasonable time frame, meets definition of "child with exceptional educational needs," consistently poor or failing grades, repeated truancy, expulsion, property damage or violence towards others.

  Describe functional deficit:_____

  _____

  _____

- **Adaptation to change that interferes with stable community life:** Repeated failure on the part of an individual to adapt to stressful circumstances associated with work, school, health, culture, family or social interaction. Any unexpected environmental change may cause agitation or exacerbation of signs and symptoms associated with the illness, or withdrawal from the stressful situation.

  Describe functional deficit:_____

  _____

  _____

And

Have a high need for intensive services and/or ongoing services due to mental illness and/or substance abuse disorder that requires more than traditional office-based services (one or more is required):

- **Risk for deterioration:**

  - Consumers who demonstrate during the past year a recurrent (more than once) need for increase in service intensity (e.g., crisis intervention-type services).

  - History of severe dysfunction sometime during the past year extending over more than a three month period even if now more stable and functional.

  Describe functional deficit:_____

  _____

  _____

- **Dangerousness:**

  Consumers who have exhibited dangerous behavior as a result of mental illness or AODA disorder.

  Describe functional deficit:_____

  _____

  _____

- **Institutionalization:**

  - Consumers who are residing in institutions (e.g., nursing home, IMD, CCI, state institutions – non forensic population), or residing in dependent living situations (e.g., CBRF, group home, adult family home, foster home) for the last three months;

  Or

  - Consumers who have been in institutional level care or dependent living situations for at least three months anytime during the past year.

  Describe institutional history/dependent living situation history:_____

  _____

  _____

- **Repeated Acute Hospitalizations:**

  - ➢ High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.

  - ➢ High use of medical detoxification (e.g., _____ per year).

  Describe functional deficit:_____

  _____

  _____

- **Mentally ill in the criminal justice system:** Consumers who are at high risk for repeated involvement in the criminal justice system for behavior assessed to be clearly related to mental illness.

  *Note: The workgroup recommended removal of this item because it is referenced in the functional deficit area.

  Describe functional deficit:_____

  _____

  _____

- **Need for ongoing services: What services are needed? (At least one of the below, directly related to maintaining stability is required.)**

  - ➢ Medication monitoring

    Problems in taking medication (refers to current status and past history).

  Describe functional deficit:_____

  _____

  _____

  - ➢ Case Management (direct help with access to system and resources)

    The consumer needs direct help in accessing or maintaining needed benefits and services including SSI, housing subsidies, medical assistance, food, shelter, clothing, medical treatment, transportation, and other necessities of daily life.

    - ✓ The consumer needs direct help in getting to appointments.

    - ✓ The consumer needs ongoing support and monitoring to stay engaged in treatment and rehabilitative services.

- ✓ The consumer needs help to coordinate treatment including linkages and referrals for services provided by multiple agencies.

Describe functional deficit:_____

_____

_____

- ➢ Crisis Services:

  - ✓ The consumer needs an active crisis plan to respond to high risk behavior.

  - ✓ During the past two years, the consumer has required a rapid increase in intensity of services to prevent hospitalization or severe disruption in his/her life.

Describe functional deficit:_____

_____

_____

ATTACHMENT 12

Comprehensive Assessment

DOMAIN 1
MENTAL HEALTH AND ALCOHOL OR OTHER DRUG ABUSE/USE

A: INFORMATION COLLECTED:

- **Onset of mental illness: age and circumstances**
  - **mental health hospitalization history- when, where, by whom, frequency, patterns (indicate court ordered or voluntary)**
  - **mental health outpatient treatment- when, where, by whom, type of treatment, results, effectiveness**
  - **medication history – dosages, side effects, effectiveness, AIMS Score**
  - **current medication listing (include all medications, prescribed and over the counter)**
  - **diagnoses- changes or consistency over time**
  - **history of behavioral issues**
  - **suicidal or homicidal thoughts or gestures**
- **Family history of mental illness, diagnoses, treatment**
  - **trauma history - physical or sexual abuse, violence, including experience in the military**
- **Patterns of substance use**
  - **age of first use**
  - **types of substances used/abused (marijuana, cocaine, opiates, prescription, etc.)**
  - **history of AODA treatment –detox, inpatient, day treatment, outpatient, self-help groups and when, where, outcome (indicate court ordered or voluntary)**
  - **family member history of AODA issues - who, what, treatment involvement**

B: CURRENT SYMPTOM PROFILE

- **describe current substance use**
- **describe current mental health symptoms**
- **describe problem solving and decision making ability**
- **relationship of substance use to mental health symptoms and functioning**

AXIS I_____AXIS II _____
AXIS III_____AXIS IV_____
AXIS V- GAF_____
Source:_____
CAFAS Score:
Mental Status Exam Narrative:

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the mental health and AODA area, including the information collected from the family interview**
  - **identify strengths; needs and implications for services, supports and treatment**
  - **attach screening information and independent review**

DOMAIN 2
SOCIAL AND COMMUNITY SUPPORTS

A: INFORMATION COLLECTED:

- **Past social involvement throughout life**
  - **Childhood friendships and socialization skills**
  - **Involvement in extra-curricular and self planned activities**
  - **History of family relationships**
  - **Family knowledge and understanding of mental illness and substance abuse**
  - **Past problems as a result of substance abuse or mental illness in relation to social and community**

B: CURRENT PROFILE

- **Current social involvement for both child and family– frequency and nature of contact with friends, stability of relationships, satisfaction with social and work supports and relationships**
- **Recreation and leisure for both child and family – ability to plan for and carry out activities, interests and hobbies, recreation activities (what, when, with whom, how often)**
- **Child's social skills – assertiveness, appropriateness, conversation skills, strengths, weaknesses and social frustrations**
- **Child's social judgement – vulnerability to others, impulsivity**
- **Child's problem solving/decision making – effectiveness, consistency, satisfaction with outcome, presenting difficulties, and avoidance**
- **Family's community support involvement – 12 step support group, peer support, church involvement, drop in center, neighborhood center, senior center**
- **Current problems associated with the use of substances in relation to social and community supports**
- **Current problems or consequences associated with the mental illness in relation to social and community supports**

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the social and community support area including:**
  - **strengths; needs and implications for services, supports and treatment**
- **Information collected from the family interview**
  - **interests and hobbies, recreation activities (what, when, with whom, how often)**
  - **family or support issues the consumer would like assistance with.**
  - **what the parent stated that he or she does when stressed.**
  - **what the parent stated that he or she does to relax.**

- **family stated desire for change and barriers to change**

DOMAIN 3
CULTURAL

A: INFORMATION COLLECTED:

- **Past problems as a result of substance abuse or mental illness in relation to cultural issues**

B: CURRENT PROFILE

- **Language barriers – note if English is a second language, hearing impairments, functional illiteracy, other language barriers**
- **Cultural authority systems – who can make decision for consumer/family**
- **Cultural/ethnic communication style**
- **Culturally specific medical beliefs or practices**
- **Consumer/family noted spiritual needs**
- **Current problems as a result of substance abuse or mental illness in relation to cultural issues**

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the cultural area including:**
  - **strengths; needs and implications for services, supports and treatment**
- **Information collected from the family interview**
  - **traditions, customs, values and beliefs identified by the family as important**
  - **parent identified religious affiliation – membership, attendance**

DOMAIN 4
INDEPENDENT LIVING SKILLS

A: INFORMATION COLLECTED:

- **Review situations which fostered independent living success and recovery**
- **Review living situations hindering success and recovery**
- **Cite other disabilities family members have that impact on independence – use of wheelchair, frailties of aging, learning disability**
- **Cite other factors that impact on independence – poverty, neighborhood safety**
- **Review reasons why activities of daily living are challenging**
- **Past problems as a result of substance abuse or mental illness in relation to independent living**

B: CURRENT PROFILE

- **Review abilities in child's self-care – hygiene, grooming, clothes shopping, laundry, housekeeping**
- **Review abilities in food related areas - meal preparation, nutrition, menu planning, grocery shopping**
- **Review transportation skills – driver's license, access to a car, bus use ability, supported transportation**
- **Parent's financial skills – independently pays bills, money management, banking and budgeting**
- **Child's safety skills – interactions with strangers, vulnerability in community**
- **Describe ability to manage medication**
- **Describe ability to parent independently**
- **Current problems associated with substance abuse or mental illness in relation to independent living skills**

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the independent living skills area including:**
  - **strengths; needs and implications for services, supports and treatment**
- **Information collected from the family interview**
  - **parent identified areas in self-care in which help is needed**
  - **parent stated goals and what is needed to achieve**
  - **transportation needs of family**

DOMAIN 5
PHYSICAL HEALTH

A: INFORMATION COLLECTED:

- **Child's medical history – note surgeries, chronic conditions or pain, physical limitations, brain injuries, other physical injuries**
- **Child's preventive health - last physical exam, prostate exam, pap smear, mammogram, immunizations**
- **Child's dental – last exam, regular brushing and flossing, teeth or gum problems**
- **Child's vision and hearing – last eye exam, uses corrective lenses or hearing aid, issues around sight or hearing**
- **Child's use of over the counter items – caffeine, tobacco, inhalants, medication, other substances**
- **Child's sexuality issues – note sexual activity, problems, concerns, contraceptive use, understanding of sexually transmitted diseases including HIV, interest in or need for further education**
- **Family medical history - cardiac problems/disease, diabetes, cancer, high blood pressure, etc.**
- **Past problems associated with substance abuse or mental illness in relation to physical health**

B: CURRENT PROFILE

- **General physical health – note exercise habits, weight loss/gain, bowel/urinary problems, sleep patterns, allergies, memory or ambulating concerns**
  - **name and phone number of physician(s)**
  - **name and phone number of dentist**
  - **describe ability to communicate medical needs and access medical care**
- **Current problems associated with substance abuse or mental illness in relation to physical health**

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the physical health area including:**
  - **strengths; needs and implications for services, supports and treatment**
- **Information collected from the family interview**
  - **Parent identified health concerns or conditions.**
  - **name of doctor and dentist parent identified**
  - **date of last doctor exam and dental exam**

DOMAIN 6
EDUCATION AND TRAINING

A: INFORMATION COLLECTED:

- **Education background of child and parents– last grade completed, additional training (GED, vocational, college, other)**
- **Parent employment**

B: CURRENT PROFILE

- **Parent and child's ability to write, read, math skills, computer literacy, interest in reading, math, other**
- **Child's current educational status– educational involvement, interests, plans, strengths**
- **Child's current vocational status or need for supported work involvement (if applicable)**
- **Current problems associated with substance abuse or mental illness in relation to education and training**

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the education and training area for parent and child including:**
  - **strengths; needs and implications for services, supports and treatment**
    - **vocational strengths/needs – physical functioning and appearance, job readiness**
- **Information collected from the family interview**
  - **parent stated education and training goals.**
  - **what the parent stated that he or she would like to do**
  - **whether the consumer indicated if he or she needs help with different life roles (homemaker, caregiver or parent).**

DOMAIN 7
LIVING/RESIDENTIAL ENVIRONMENT

A: INFORMATION COLLECTED:

- **Past living arrangements of family and child (if different) – locations, types (apartment, group home, supervised apartment) length of stays, roommates or alone, ability to manage daily living activities (upkeep, landlord/ roommate/neighbor relations) bill payment, satisfaction**
  - **include information about homelessness, evictions, shelter use**
  - **describe past living situations/arrangements that have been unsuccessful**
  - **describe past living arrangements that were successful**
- **Past problems associated with substance abuse or mental illness in relation to living/residential environment**

B: CURRENT PROFILE

- **Describe current living arrangements - # of people in household, # of rooms, adequate space, privacy, other children**
- **Safety – neighborhood safety, building safety (deadbolt locks) physical or sexual abuse (victim or perpetrator), fires**
- **Current problems associated with substance abuse or mental illness in relation to living/residential environm**ent

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the living residential environment area including:**
  - **strengths; needs and implications for services, supports and treatment**
- **Information collected from the family interview**
  - **parent identified areas within household maintenance which help is needed.**
    - **does the family feel safe**
    - **is the parent interested in receiving help finding another place to live**
    - **parent desired changes – stated needs and goals, barriers to goals, things that need to occur for change to happen and for the child to return home**

DOMAIN 8
LEGAL

A: INFORMATION COLLECTED:

- **Child's history of legal issues – review arrests and circumstances involved, convictions, sentences, emergency detentions, OWI**
- **Parent legal issues – custody arrangements, significant history and any current legal constraints**
- **Other legal issues – citizenship, advanced directives, living wills, protective services, power of attorney (activated?)**
- **Past problems associated with substance abuse or mental illness in relation to the legal area**

B: CURRENT PROFILE

- **Review current legal issues – commitment, protective services or placement, guardianship, probation, parental rights, pending litigation, restraining**

order, civil actions (note names of pertinent people, e.g. parole officer, attorney, etc.)

- **Legal assistance needed- restraining orders, divorce, etc.**
- **Current problems associated with substance abuse or mental illness in relation to the legal system**

C: SUMMARY, EVALUATION AND TREATMENT RECOMMENDATIONS

- **Summary of the legal area including:**
  - **strengths; needs and implications for services, supports and treatment**
- **Information collected from the family interview**

ATTACHMENT 13

Consumer Completed Questionnaire
Information collected is used to complete the comprehensive assessment

NAME _____ **DATE OF BIRTH** _____

How would you like to be addressed? _____

1. What are the things going well in your life? _____

2. What are the things you do well? _____

3. What do you do to help yourself? _____

4. What are the things that are bothering you the most? _____

5. What areas do you want help in the most? _____

6. How can we be most useful to you? _____

7. Who are the people most important to you?

NAME **RELATIONSHIP**

8. **If there are issues or concerns that you would like assistance with regarding any of the people above, please describe:**

9. **Would you rather spend time: alone ❑ with others ❑ alone and with others ❑**

10. **If you have a spouse, partner or significant other, what is his/her name?** _____

11. **Do you have a friend to do things with? YES ❑ NO ❑**

12. **Who do you go to for support?** _____

13. **What do you do for fun, hobbies or recreation?** _____

14. **What are some things you would like to do for fun or recreation that you are not doing now?**

15. **If you have pets, what kind of pet(s) do you have?** _____

16. **Would you like a pet? YES ❑ NO ❑ If YES, what kind of pet(s) would you like?** _____

17. **What do you do to relax?** _____

18. **What do you do when you are stressed?** _____

19. If there are any organizations, clubs or groups that are important to you, please name them:

20. Is religion important to you? YES ❑ NO ❑ Do you have spiritual beliefs? YES ❑ NO ❑

If there are traditions, customs, holidays or anniversaries that are important for us to know about, what are they?

22. Please describe anything about your cultural background that is important for us to know?

23. Would you like help in learning how to manage your money? YES ❑ NO ❑

24. Do you need help in any of the following areas?

Cooking	**YES ❑**	**NO ❑**	**Using a phone book**	**YES ❑**	**NO ❑**
Grocery shopping	**YES ❑**	**NO ❑**	**Laundry**	**YES ❑**	**NO ❑**
Shopping for clothing	**YES ❑**	**NO ❑**	**Paying bills**	**YES ❑**	**NO ❑**
Household chores (dishes, cleaning, taking the trash out)	**YES ❑**	**NO ❑**	**Home maintenance (snow removal, mowing the lawn)**	**YES ❑**	**NO ❑**

Other areas around the house where you need help.

25. How do you get to the places you want to go?

26. Do you need help with transportation? YES ❑ NO ❑

27. If you have a medical doctor, what is his/her name?

28. Describe any physical health concerns or conditions you have.

29. If you have a dentist, please give name?

30. Describe any dental health concerns or conditions you have.

31. If you have difficulty with personal care tasks such as showering/bathing, brushing your teeth, etc., please list the tasks you have difficulty with.

32. Do you get enough sleep? YES ❑ NO ❑

33. Do you think you get enough exercise? YES ❑ NO ❑

If you answered NO to enough sleep or exercise, how could we help?

34. Have you received information about the condition(s) that brought you here? YES ❑ NO ❑

35. Please list any medications you are taking regularly, including over the counter medications.

36. Have you received information about these medications? YES ❑ NO ❑

37. If you have side effects from your medications, what are they?

38. Do you feel that your condition has improved? YES ❑ NO ❑

39. Do you feel hopeful that your condition will improve? YES ❑ NO ❑

40. Where are you on the road to recovery? (please mark the point on the scale below with #1 being "not in recovery" to #10 being "fully recovered")

Not in recovery 1 2 3 4 5 6 7 8 9 10 fully recovered

41. What has been helpful in your recovery?

42. How far did you go in school?

Please list degree(s) or certificate(s) earned. _____

43. Describe any educational or training goals you have. _____

_____

44. If you served in the military, which branch? _____

Dates of military service: _____ **Type of discharge from the military:** _____

45. If you have a paying job, how long have you worked there? _____

46. How many hours a week do you work at your paying job? _____

47. If you are not working, what would you like to do? _____

48. Do you volunteer? YES ❑ NO ❑ If yes, how many hours a week do you volunteer? _____

49. If you are a homemaker, caregiver and/or parent, how can we help you with these responsibilities?

_____

_____

50. What other work or responsibilities do you have? _____

_____

51. Please name any professional skills or interests not listed that you have or would like.

_____

_____

52. Please describe any work or professional career goals you have.

_____

53. Where do you live? ❑ **house** ❑ **apartment** ❑ **group home**
❑ **with parents** ❑ **shelter** ❑ **institution**

Other: _____

54. How long have you lived there? _____

55. If you are unhappy with your living situation, what would help to improve it?

_____

_____

56. Do you feel safe? YES ❑ NO ❑

57. Please check if you have any special needs in the following:

Physical accessibility **YES** ❑ **NO** ❑
Attendant care **YES** ❑ **NO** ❑
Adaptive equipment **YES** ❑ **NO** ❑

Person, if other than consumer, completing this form. _____ **Date:** _____

Service Coordinator: I have discussed the information with the consumer.

_____ **Date:** _____

Consumer signature: I have provided the information and agree with it.

_____ **Date:** _____

ATTACHMENT 14

Parent Interview

Child/Family Narrative Interview Questions ("you/your child" are interchangeable to be asked of the child and/or parent/guardian as determined appropriate by the interviewer and refer to the child and/or parent/guardian)

Domain 1, Mental Health and Alcohol or Other Drug Abuse/Use

- What do you consider to be your strengths and what are the things you do well?
- What are the things going well in your life?
- What are the things that are bothering you the most?
- Do you have concerns about keeping your child in your home?
- Do you need assistance in keeping your child in your home? What would help?
- Does your child have behaviors that you don't want other siblings exposed to?
- What would have to happen to have your child return home (if out of family home)?
- Have you received information about your/your child's mental health/alcohol and other drug abuse (MH/AODA) condition(s)? If yes, from whom?
- Have you received or are you receiving MH/AODA treatment? If yes who did/is providing treatment?
- What safety concerns do you have for yourself or others around you?
- Have you or others in your family talked about or had any suicidal thoughts or attempts? If yes, please describe.
- Do you or others in your family use alcohol or other drugs? If yes what is used, how often, what effect does it have on self or family?
- What do you do to relax?
- What do you do when you are stressed?
- What has been helpful in your recovery? (recovery means the successful integration of a mental disorder into a consumer's life)
- What MH/AODA areas do you want help in the most?
- How can we be most useful to you?

Domain 2, Physical Health

- Generally, how is your physical health? Do you eat well, get enough exercise, would you like help with these items?
- Do you have physical health conditions we should be aware of such as asthma, allergies, diabetes etc.?
- Do you have any special needs with the following:
  ____ Physical accessibility ____ Attendant care
  ____ Adaptive equipment ____ Respite Services
- Do you have physical disabilities we should be aware of?
- Do you have any sleep difficulties, if yes, what do you think would help?

- Are you getting treatment or did you receive treatment for any health/physical health issues? If yes, what treatment did you receive or are presently receiving and who did/is providing it?
- Do you feel hopeful that your condition will improve?
- Are you taking medications regularly including over the counter medications? Who is prescribing the medications? How are they monitored?
- Have you received information about these medications?
- Have there been any side effects from the medications?
- How has your condition improved?

Domain 3, Social and Community Supports

- Who are the people most important to you, and your family? Would you like these people involved in treatment planning with you?
- Please describe if there are issues or concerns that you would like assistance with regarding any of these people.
- Would you rather spend time: ____alone ____with others ____ alone and with others
- Do you have a friend/friends to do things with?
- Do you need respite services?
- Do you have respite services? If yes, how often do you use respite?
- Who do you go to for support?
- What are the things you and/or your family do for fun or recreation?
- What are some things you and/or your family would like to do for fun or recreation that you are not doing now? Why are you not doing them now?
- If there are any organizations, clubs or groups that are important to you please name them: (church, temple, sport groups, Big Brothers/Big Sisters, scouts, etc.)
- Would you like some ideas about recreational activities, organizations, clubs or groups?

Domain 4, Cultural/Spiritual/Personal Beliefs

- Are there customs, spiritual beliefs holidays or anniversaries that are important for us to know about?
- Are there alternative treatments that you use such as herbal remedies, healing ceremonies, etc.? If yes, what are they?

Domain 5, Independent Living Skills

- Do you need help in any of the following areas?
  _____Cooking
  _____Grocery shopping
  _____Shopping for clothing
  _____Using a phone book
  _____Laundry
  _____Paying bills
  _____Household chores (dishes, cleaning, taking the trash out)

_____Home maintenance (snow removal, mowing the lawn)
_____Getting places you want or need to go to
_____Money management

- Other areas where you need help? _____

Domain 6, Education and Training

- How are things at school for you?
- Do you feel you have enough information about how your child is doing at school?
- What things at school are troubling/difficult for you?
- Do you get to school on time? If no, how often do you miss or are late to school?
- Any Suspensions/expulsions? If yes please describe.
- What is the last grade you completed in school?
- Please list degree(s) or certificate(s) earned.
- Describe any educational/work/training/career goals you have.
- If you served in the military, which branch, dates of military service, type of discharge.
- Are you presently working? If yes, where, how many hours, how long have you been at this job?
- Other jobs you have had in the past? Employment dates, reason for leaving?
- What other work or responsibilities do you have?
- Do you need help with your childcare or parenting responsibilities?
- Please name any professional skills or interests not listed that you have or would like.

Domain 7, Living/Residential Environment

- How long have you lived in your current residence? Where else have you lived in the past 5 years? (locations and dates)
- Who else lives in your home? Are there any concerns about this/these person?
- Do you have responsibilities for the care/expenses for others in your home or at their home?
- If you are unhappy with your living situation, what would help to improve it?
- Do you feel safe in your home and neighborhood?
- Do you have pets in your home? Who is responsible for them?
- Would you like information about energy assistance or other programs that could help with housing expenses?

Domain 8, Legal

- Are there any legal issues you need help with? If yes what are they?
- Do you need special assistance with your legal involvement such as a public defender, advocate etc?

ATTACHMENT 15

Plan of Care Requirements

Timing:

The care coordinator is responsible for developing an initial treatment and recovery plan of care (POC), at the time of enrollment into the managed care system. The treatment and recovery team is responsible for developing the comprehensive POC within 60 days of enrollment and updated as needed or at least every six months.

Team Membership:

The treatment and recovery team shall be listed on the POC and consists of the following:

- The consumer
- The care coordinator
- Formal supports (service provider staff)
- Informal caregivers (supportive people the consumer identifies such as family members, neighbors or advocates)

Components of the Plan of Care:

The POC is based upon the strengths, needs and consumer preferences identified in the comprehensive assessment. The POC shall include the following:

- Consumer's recovery goals and preferences as identified on the consumer completed questionnaire
- Specific measurable short and long term goals
- Services and supports to be provided to meet identified needs and goals
- Measurable completion criteria and expected outcomes for each identified goal
- Each specific team member's responsibility in providing interventions
- Informal supports involved and what they provide
- Other person's role in providing services and supports (if not on the team)
- Specific time lines for the services and supports delivered
- Consumer's financial liability (if any)
- Transitional services and plan
- An individual crisis plan

Written Requirements:

The POC shall clearly illustrate how services and supports are coordinated regardless of payer source. Any changes in team membership shall be documented as the changes occur. The consumer and all team members attending the meeting must sign the POC indicating their agreement to the plan. It is the care coordinator's responsibility to document the content of team meeting discussions as well as client and individual team member contacts between team meetings.

ATTACHMENT 16

Wisconsin Medicaid "Medically Necessary" Definition

(96m) "Medically necessary" means a medical assistance service under ch. HFS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

6. Is not duplicative with respect to other services being provided to the recipient;

7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

ATTACHMENT 17

"Category A" Services For Integrated Models

- Physicians' services
- Early and periodic screening, diagnosis and treatment (EPSDT) of persons under 21 years of age
- Rural health clinic services
- Medical services if prescribed by a physician:
  - ♦ Inpatient hospital services other than services in an institution for mental disease (IMD)
  - ♦ Outpatient hospital services
  - ♦ Skilled nursing home services other than in an IMD
  - ♦ Home health services, or nursing services if a home health agency is unavailable
  - ♦ Laboratory and x-ray services
  - ♦ Family planning services and supplies
  - ♦ Intermediate care facility (ICF) services, other than IMD services
  - ♦ Physical and occupational therapy
  - ♦ Speech, hearing and language disorder services
  - ♦ Medical supplies and equipment
  - ♦ Inpatient hospital, skilled nursing facility and ICF services for patients in IMDs:
    - -- who are under 21 years of age
    - -- are under 22 years of age and received services immediately prior to reaching age 21
    - -- who are 65 years of age or older
  - ♦ Medical day treatment, mental health and alcohol and other drug abuse services, including services provided by a psychiatrist. These services include:
    - ➢ Assessment/Evaluation/Diagnostic Testing
    - ➢ Individual/Family Psychotherapy
    - ➢ Group Psychotherapy
    - ➢ Collateral Contacts
    - ➢ Medication Management
    - ➢ Individual/Family AODA therapy
    - ➢ Group AODA therapy
  - ♦ Nursing services, including services performed by a nurse practitioner
  - ♦ Legend drugs and over-the-counter drugs listed in the Wisconsin's MA drug index
  - ♦ Personal care services
  - ♦ Alcohol and other drug abuse day treatment services

- ♦ Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- ♦ Respiratory care services for ventilator-dependent individuals

- Dentists' services
- Nurse midwifery services
- Optometrists' or opticians' services, including eyeglasses
- Transportation:
  - ♦ By emergency medical vehicle to obtain emergency medical care
  - ♦ By specialized medical vehicle to obtain medical care
  - ♦ By common carrier or private motor vehicle if authorized in advance by a county
- Chiropractors' services
- Case management services
- The following new Medicaid benefits, if adequate data is available to incorporate these into the capitation rate:
  - ♦ Community psychotherapy services
  - ♦ AODA residential treatment
  - ♦ Community-based psychosocial services
- Hospice care
- Podiatrists' services
- Care coordination for women with high-risk pregnancies
- Care coordination and follow-up of persons having lead poisoning or lead exposure, including lead inspections
- Premiums, deductibles and coinsurance and other cost-sharing obligations for services otherwise paid under MA that are required for enrollment in a group health plan
- Payment of any of the deductible and co-insurance portions of the services listed above which are paid under Medicare and the monthly Part B premiums payable under the federal Social Security Act
- Prenatal, post partum and young child care coordination services for certain residents of Milwaukee County.
- Mental health crisis intervention services.
- School medical services
- Intensive in-home treatment and child/adolescent day treatment under the authority of HealthCheck "other services".

ATTACHMENT 18

"Category A" Services For Carve-Out Models

- **Inpatient Services**
  - ♦ Mental Health and AODA Inpatient Services
- **Outpatient Clinic Services or Hospital Outpatient Services**
  - ♦ Assessment/Evaluation/Diagnostic Testing
  - ♦ Individual/Family Psychotherapy
  - ♦ Group Psychotherapy
  - ♦ Collateral Contacts
  - ♦ Medication Management
  - ♦ Individual/Family AODA therapy
  - ♦ Group AODA therapy
- **Medical Day Treatment for Adults**
- **AODA Day Treatment**
- **Community Support Program Services**
- **Targeted Case Management Services**
- **Mental Health Crisis Intervention**
- **Intensive In-Home Treatment**
- **Child/Adolescent Day Treatment**
- **The following new Medicaid benefits, if adequate data is available to incorporate these into the capitation rate**
  - ➢ Community psychotherapy services
  - ➢ Community-based psychosocial services
  - ➢ AODA residential treatment

ATTACHMENT 19

"Category B" Services From BRC Final Report And Wisconsin Uniform Placement Criteria (UPC)

SERVICES FROM BRC:

(Some of these activities may also be components of category A services, e.g., symptom management is included in the CSP benefit package.)

- Client Identification, Information and Referral
- Client Outreach
- Relapse Prevention
- Symptom Management
- Case Consultation
- Respite
- Mentoring/Parent/Child Aides
- Social Supports
- Self-help, Peer Support
- Psychoeducation
- Access to Physical and Dental Services
- Supportive Services
- Educational, Vocational
- Parent Skill Training
- Housing Supports
- Benefits Assistance
- Transition Services
- Activities Daily Living
- Client Rights Protection
- Medication*
- Transportation*
- Court Evaluations
- Jail Diversion
- Comm. Supervision
- Crisis Homes/Beds
- Residential Services
- Long-Term Institution*

SERVICES FROM UPC:

- Non-Medical, Non-Ambulatory Intoxication Monitoring Service
- Ambulatory Withdrawal Service
- Medically Monitored, Non-Ambulatory Withdrawal Service
- Residential Treatment Service

* These are Category A services for Medicaid-eligible individuals in integrated models.

ATTACHMENT 20

BRC Consumer Outcomes

Consumer Satisfaction: The consumer of mental health services experiences that his/her thoughts and feelings about both life in general and specific mental health services have value and influence the direction of treatment. Both content and process of addressing consumer satisfaction make a contribution, one in providing necessary information (feedback), the other in affirming the worth of the person receiving services and in supporting his/her empowerment.

Empowerment: The mental health consumer gains a growing confidence of his/her ability to meet the challenges of life with a mental illness. There is meaningfull involvement in the process of treatment, and participation in one's own care with the exercise of choices about both services and activities of daily living. Along with empowerment comes increasing personal responsibility, self-sufficiency, dignity, respect, and hope.

Access: Persons with mental illness receive needed services on a timely basis. Barriers to access are reduced. Interventions with persons needing services are increasingly available to allow for timely access while minimizing the use of involuntary treatment. Involvement with self-help and peer support resources are encouraged and supported.

Safety: Persons with a mental illness are assisted to refrain from behaviors which will be life threatening to themselves or which will pose a danger to others. They are safe and free from abuse in their daily living environments and relationships. If there is a lawful restriction of personal freedom, treatment is provided. Needed treatment and supportive services are not withheld or threatened, are secure and continue to be available over time.

Awareness: Consumers, key service sectors (e.g., schools, medical clinics, churches, police) and the general public grow in their knowledge of mental illnesses, of services needed for effective treatment and recovery, of the positive effects of self-help and peer support, and of the organization of the mental health system. Increased awareness contributes to self-referral for treatment and to early case finding by families, friends, and others who have regular contact with the public.

Equal Opportunity: Persons with a mental illness are free of stigma, especially in the treatment arena, and exercise the full rights of citizenship. There is parity in insurance benefits between mental illness and other illnesses. Rights of persons in treatment are protected, due process observed.

Symptom Reduction: The troublesome symptoms of a person's mental illness and/or behavioral disorder are reduced. Reduction in symptoms is beneficial as relief of suffering as well as contributing to increased capacity to achieve other positive consumer outcomes. The person has increased mastery and control of the symptoms of the mental illness, and increased ability to live a full and productive life despite the mental illness.

Psychological Well-Being: Persons with a mental illness experience improved emotional and spiritual health. They feel better about themselves and have more fun. The effect of their psychological status on the illness is understood and acknowledge.

Physical Health: Persons with a mental illness pay attention to their physical health and receive appropriate medical attention for health risks and problems. Medications side-effects are reduced and treated, especially in regard to dental care. This outcome will have different aspects at different life stages, including the need to prevent pregnancies for teenagers, and for older persons the maintenance of health and timely and accurate identification of problems of aging.

Social Relations and Supports: Persons with a mental illness are involved in the community, have age-appropriate positive involvement with family members, have friends and the opportunity for intimate relationships, non-stigmatized social roles and places to live. Natural supports contribute to successful treatment and recovery.

Meaningful Activities and Occupations: Persons with a mental illness have full days and develop toward their full potential. Involvements in age appropriate actives are maximized, including youth in regular schools, adults in regular jobs or other appropriate activity, and other persons in community retirement activities.

Goal Attainment: Person with a mental illness choose and realize personal goals. Specific personal skills are developed, with objective progress over time.

Basic Survival: Persons with a mental illness have adequate income to consistently meet daily needs for food, clothing, shelter, and transportation. Housing meeting community standards and is affordable.

Freedom from Substance Abuse: Persons with a mental illness are free from alcohol or other drug abuse. Alcohol/drug problems are identified at an early stage; timely and effective treatment is provided.

Daily Living Skills: The person with a mental illness grows in the ability to take care of him/herself. For most persons with a mental illness, skills requiring special attention are less oriented toward medical personal care skills, more oriented toward money management, cooking skills, time management, problem-solving, and interpersonal skills.

ATTACHMENT 21

Performance Indicators

Description of Proposed Indicator	Type of Indicator	Domain BRC/MA	Data Source
1. Enrollees report that they feel they are actively involved in the development of goals for their treatment plan.	Non-clinical	Enrollee rights, empowerment.	Enrollee survey.
2. Total number of formal grievances, complaints and appeals generated per year.	Non-clinical	Grievances, complaints and appeals. Also Satisfaction.	Managed Care Organization (MCO) Grievance log.
3. Number of formal grievances, complaints and appeals generated by service denials per year.	Non-clinical	Grievances, complaints and appeals. Also Satisfaction.	MCO Grievance log.
4. Inpatient days per 100 enrollees for Mental Health/Substance Abuse (MH/SA) diagnoses.	Non-clinical	Access to services.	HSRS MH Module, field 25, SA module, field 30, code 503 in each.
5. Percentage of enrollees with MH or SA diagnosis with primary or shared custody of children under age 18.	Non-clinical	Support and family structure. Community living outcome.	HSRS MH module, field 16b and CSP Report.
6. Percentage of adult enrollees age 18-65 with non-sheltered paid employment of: • 35 or more hrs/wk • 20-34 hrs/wk • Less than 20 hrs/wk	Non-clinical	Meaningful activities and occupations.	HSRS SA module, field 16, 17 and 24. New HSRS MH consumer status data set will collect this information.
7. Number of Chapter 51 emergency detentions per year.	Non-clinical and clinical.	Goal attainment, relapse prevention. Clinical goal of symptom reduction.	HSRS MH module field 9b.
8. Percentage of adult enrollees age 18-65 involved in meaningful activities.	Non-clinical	Meaningful activities and occupations	Consumer survey, HSRS outcome.
9. Reported abstinence or reduction of substance abuse at 6, 12 and 18 months (or six month intervals) after enrollment.	Clinical	Goal attainment, symptom reduction, timely and effective treatment.	HSRS SA module, fields 26, 37 and 38.

Description of Proposed Indicator	Type of Indicator	Domain BRC/MA	Data Source
10. Average number of days from discharge from acute care for MH or SA diagnosis until delivery of follow-up care by MH/SA provider.	Clinical	Continuity of care, access to care, relapse prevention.	Case management or medical records.
11. Percentage of readmissions to detoxification centers per year.	Clinical	Continuity of care, access to care, relapse prevention.	HSRS SA module, field 30.
12. Rate of incarcerations per year among enrollees.	Clinical	Continuity of care, access to care, relapse prevention. Crisis intervention.	HSRS SA module field 20, MH module fields 9a and 11.
13. Percentage of individuals with MH diagnosis with reduced symptoms (severity) related to the diagnosis at six and twelve months after the close of care.	Clinical	Prevention and care of chronic conditions, symptom reduction.	Standard assessment data, consumer survey or HSRS MH module, field 10.
14. Percentage of enrollees being treated with antipsychotic medications that are receiving atypical antipsychotic medications.	Clinical	Care of chronic and acute conditions.	Medical record.
15. Suicide rate among enrollees.	Clinical	Continuity of care, effective-ness of care, personal safety, crisis intervention.	Coroner records and/or medical records.
16. Percentage of enrollees having medical, dental and vision health appointments each year.	Clinical	Physical health, access.	Medical record.

ATTACHMENT 22

Wisconsin Medicaid HMO Encounter Data Set

The following are encounter data fields that are used in Wisconsin Medicaid's AFDC HMO program. This list is included to suggest the type and range of information that may be collected as part of the MH/AODA managed care demonstrations. No final decisions have been made about encounter data sets for the demonstrations.

Note that not all data is reported for all encounters--the key under encounter types is as follows: R=required; o=optional; N=not required; RA=required if applicable. For instance, the admission date is required only for inpatient services. Billing provider IDs are only required if there was a billing provider.

Encounter Date Field Testing Level			***Position***			***Encounter Types***					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
I	1	Encounter Type	1	1	PIC X (01)	R	R	R	R	R	D, I, O, M, P
I	2	HMO Medicaid ID	2	9	PIC 9 (08)	R	R	R	R	R	69XXXXXX number
I	3	Data Source	10	10	PIC 9 (01)	R	R	R	R	R	1, 2, 3
I	4	Record Type	11	11	PIC X (01)	R	R	R	R	R	O (Original) R (Reversal)
I	5	Record Identification Number	12	41	PIC X (30)	R	R	R	R	R	ICN (Internal Control Number)
I	6	Process Date	42	49	PIC 9 (08)	R	R	R	R	R	MMDDYYYY
I	7	Billing Provider ID	50	57	PIC 9 (08)	RA	RA	RA	RA	RA	Medicaid ID for group/clinic
I	8	Billing Provider Name	58	92	PIC X (35)	RA	RA	RA	RA	RA	Name of group/clinic
I	9	Recipient ID	93	102	PIC 9 (10)	R	R	R	R	R	Recipient MID number
II	10	Recipient Last Name	103	137	PIC X (35)	R	R	R	R	R	
II	11	Recipient First Name	138	162	PIC X (25)	R	R	R	R	R	
II	12	Recipient Middle Initial	163	163	PIC X (01)	O	O	O	O	O	
II	13	Other Provider	164	198	PIC X (35)	N	O	N	N	N	
II	14	Attending Physician	199	233	PIC X (35)	N	O	O	N	N	

Encounter Date Field Testing Level			*Position*			*Encounter Types*					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
II	15	Referring Provider ID	234	241	PIC 9 (08)	N	N	N	O	N	Referring Provider Number
II	16	Facility Name or Number	242	276	PIC X (35)	N	N	N	RA	O	Facility where service was done
I	17	Principle Diagnosis Code	277	282	PIC X (06)	N	R	R	R	N	ICD-9 Diagnosis Code
I	18	Second Diagnosis Code	283	288	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	19	Third Diagnosis Code	289	294	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	20	Fourth Diagnosis Code	295	300	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	21	Fifth Diagnosis Code	301	306	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	22	Sixth Diagnosis Code	307	312	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	23	Seventh Diagnosis Code	313	318	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	24	Eight Diagnosis Code	319	324	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	25	Ninth Diagnosis Code	325	330	PIC X (06)	N	RA	RA	RA	N	ICD-9 Diagnosis Code
II	26	Admission Diagnosis Code	331	336	PIC X (06)	N	R	N	N	N	ICD-9 Diagnosis Code
I	27	DRG (Diagnosis Related Group)	337	339	PIC X (03)	N	RA	N	N	N	
II	28	Principle ICD Procedure Code	340	344	PIC X (05)	N	RA	N	N	N	
II	29	First Other ICD Procedure Code	345	349	PIC X (05)	N	RA	N	N	N	
II	30	Second Other ICD Procedure Code	350	354	PIC X (05)	N	RA	N	N	N	

Encounter Date Field Testing Level			*Position*			*Encounter Types*					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
II	31	Third Other ICD Procedure Code	355	359	PIC X (05)	N	RA	N	N	N	
II	32	Fourth Other ICD Procedure Code	360	364	PIC X (05)	N	RA	N	N	N	
II	33	Fifth Other ICD Procedure Code	365	369	PIC X (05)	N	RA	N	N	N	
II	34	Admissio n Type	370	370	PIC 9 (01)	N	R	N	N	N	1, 2, 3, 4
II	35	Admissio n Source	371	371	PIC X (01)	N	O	N	N	N	
II	36	Patient Status Code	372	373	PIC X (02)	N	R	N	N	N	
II	37	Admissio n Date	374	381	PIC 9 (08)	N	R	N	N	N	MMDDYYYY
II	38	Value Code	382	383	PIC X (02)	N	O	O	N	N	
II	39	Value Amount	384	390	PIC 9 (07)	N	O	O	N	N	Implied decimal, 2 places
II	40	Second Value Code	391	392	PIC X (02)	N	O	O	N	N	
II	41	Second Value Amount	393	399	PIC 9 (07)	N	O	O	N	N	Implied decimal, 2 places
II	42	Third Value Code	400	401	PIC X (02)	N	O	O	N	N	
II	43	Third Value Amount	402	408	PIC 9 (07)	N	O	O	N	N	Implied decimal, 2 places
II	44	Fourth Value Code	409	410	PIC X (02)	N	O	O	N	N	
II	45	Fourth Value Amount	411	417	PIC 9 (07)	N	O	O	N	N	Implied decimal, 2 places
II	46	Occurrenc e Code	418	419	PIC X (02)	N	O	O	N	N	
II	47	Occurrenc e Code Date	420	427	PIC 9 (08)	N	O	O	N	N	MMDDYYYY
II	48	Second Occurrenc e Code	428	429	PIC X (02)	N	O	O	N	N	

Encounter Date Field Testing Level			*Position*			*Encounter Types*					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
II	49	Second Occurrence Code Date	430	437	PIC 9 (08)	N	O	O	N	N	MMDDYYYY
II	50	Third Occurrence Code	438	439	PIC X (02)	N	O	O	N	N	
II	51	Third Occurrence Code Date	440	447	PIC 9 (08)	N	O	O	N	N	MMDDYYYY
II	52	Fourth Occurrence Code	448	449	PIC X (02)	N	O	O	N	N	
II	53	Fourth Occurrence Code Date	450	457	PIC 9 (08)	N	O	O	N	N	MMDDYYYY
II	54	Condition Code	458	459	PIC X (02)	N	O	O	N	N	
II	55	Second Condition Code	460	461	PIC X (02)	N	O	O	N	N	
II	56	Third Condition Code	462	463	PIC X (02)	N	O	O	N	N	
II	57	Fourth Condition Code	464	465	PIC X (02)	N	O	O	N	N	
I	58	From Date of Service	466	473	PIC 9 (08)	R	R	R	R	N	MMDDYYYY
I	59	To Date of Service	474	481	PIC 9 (08)	N	R	N	N	N	MMDDYYYY
II	60	Prescription Date	482	489	PIC 9 (08)	N	N	N	N	R	MMDDYYYY
II	61	Fill Date	490	497	PIC 9 (08)	N	N	N	N	R	MMDDYYYY
I	62	National Place of Service	498	499	PIC 9 (02)	R	N	N	R	O	
II	63	National Type of Service	500	501	PIC X (02)	N	N	N	R	N	
I	64	Procedure Code	502	506	PIC X (05)	R	N	RA	RA	N	CPT-4, ADA, HCPCS codes, etc.
I	65	1st. Modifier Code	507	508	PIC X (02)	RA	N	RA	RA	N	
II	66	2nd. Modifier Code	509	510	PIC X (02)	RA	N	RA	RA	N	

Encounter Date Field Testing Level			*Position*			*Encounter Types*					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
I	67	Revenue Code	511	513	PIC X (03)	N	RA	RA	RA	N	
I	68	NDC Code	514	524	PIC X (11)	N	N	N	N	R	National Drug Code
I	69	Quantity	525	533	PIC 9 (09)	R	R	R	R	R	Implied decimal, 3 places
II	70	Days Supply	534	536	PIC 9 (03)	N	N	N	N	R	
I	71	Performing Provider ID	537	544	PIC 9 (08)	RA	N	N	RA	N	Medicaid ID for performer
I	72	Performing Provider Name	545	579	PIC X (35)	RA	N	N	RA	N	Name of performing
II	73	Prescriber Number (DEA Number)	580	588	PIC X (09)	N	N	N	N	R	
II	74	Prescription Number	589	596	PIC X (08)	N	N	N	N	R	
II	75	Refill Indicator	597	598	PIC 9 (02)	N	N	N	N	R	0-99
II	76	Unit Dose	599	599	PIC 9 (01)	N	N	N	N	R	0, 1, 2, 3
II	77	DAW (Dispense as written)	600	600	PIC 9 (01)	N	N	N	N	R	Dispense as written; 0-8
II	78	Emergency Service Indicator	601	601	PIC X (01)	N	N	N	R	N	Y, N
II	79	HealthCheck Referral Indicator	602	602	PIC X (01)	R	N	N	R	N	Y, N
II	80	Family Planning Indicator	603	603	PIC X (01)	N	N	N	R	N	Y, N
II	81	Charges	604	612	PIC 9 (09)	R	R	R	R	R	Implied decimal, 2 places
II	82	TPL Paid Amount	613	619	PIC 9 (07)	RA	RA	RA	RA	RA	Implied decimal, 2 places
I	83	ANSI Code 1	620	622	PIC X (03)	RA	RA	RA	RA	RA	ANSI Code 1
I	84	ANSI Code 2	623	625	PIC X (03)	RA	RA	RA	RA	RA	ANSI Code 2
I	85	ANSI Code 3	626	628	PIC X (03)	RA	RA	RA	RA	RA	ANSI Code 3
I	86	ANSI Code 4	629	631	PIC X (03)	RA	RA	RA	RA	RA	ANSI Code 4

Encounter Date Field Testing Level			*Position*			*Encounter Types*					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
I	901	HMO Medicaid ID	1	8	PIC 9 (08)						69XXXXXX number
I	902	Submission Date	9	16	PIC 9 (08)						MMDDYYYY
I	903	Beginning Process Date	17	24	PIC 9 (08)						MMDDYYYY
I	904	Ending Process Date	25	32	PIC 9 (08)						MMDDYYYY
I	905	Number of Records Transmitted	33	40	PIC 9 (08)						
I	906	HMO Contract Administrator Last Name	41	75	PIC X (35)						
I	907	HMO Contract Administrator First Name	76	100	PIC X (25)						
I	908	HMO Contract Administrator e-mail	101	150	PIC X (50)						
I	909	HMO Primary Technical Contact Last Name	151	185	PIC X (35)						
I	910	HMO Primary Technical Contact First Name	186	210	PIC X (25)						
I	911	HMO Primary Technical Contact e-mail	211	260	PIC X (50)						
	912	HMO Second Technical Contact Last Name	261	295	PIC X (35)						

Encounter Date Field Testing Level			*Position*			*Encounter Types*					
Test Level	**Field No.**	**Field Name**	**Starting**	**Ending**	**Format**	**Dental**	**In-patient**	**Out-patient**	**Medical**	**Pharmacy**	**Values**
I	913	HMO Second Technical Contact First Name	296	320	PIC X (25)						
I	914	HMO Second Technical Contact e-mail	321	370	PIC X (50)						
	915	HMO Third Technical Contact Last Name	371	405	PIC X (35)						
	916	HMO Third Technical Contact First Name	406	430	PIC X (25)						
	917	HMO Third Technical Contact e-mail	431	480	PIC X (50)						

ATTACHMENT 23

Frequently Asked Questions About the Security and Electronic Signature Standards

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1. What is the purpose of the new Security and Electronic Signature standards?

The new standards have been developed to protect the confidentiality, integrity, and availability of individual health information.

2. Why were new Security and Electronic Signature standards needed?

No existing standard provides uniform, comprehensive protection of individual health information. Health Insurance Portability and Accountability Act (HIPAA) mandates new security standards to protect an individual's health information, while permitting the appropriate access and use of that information by health care providers, clearinghouses, and health plans. HIPAA also mandates that a new electronic signature standard be used where an electronic signature is employed in the transmission of a HIPAA standard transaction.

3. What problems do these standards address? solve?

The new Security Standard will provide a standard level of protection in an environment where health information pertaining to an individual is housed electronically and/or is transmitted over telecommunications systems/networks.

The Electronic Signature Standard will provide a reliable method of assuring message integrity, user authentication, and non-repudiation.

4. How will the standard protect individual health information?

The standard mandates safeguards for physical storage and maintenance, transmission, and access to individual health information.

5. How will the new standard be implemented?

Implementation will depend upon numerous factors, e.g., the configuration of the entity implementing it, the technology it employs, and the risks to and vulnerabilities of the information it must protect.

6. Who must comply with the Security Standards?

Any health care provider, health care clearinghouse, or health plan who electronically maintains or transmits health information pertaining to an individual.

7. Who must comply with the Electronic Signature standard?

Any health care provider, health care clearinghouse, or health plan that employs an electronic signature in the transmission of one of the transactions adopted under HIPAA.

8. Do security requirements apply only to the transactions adopted under HIPAA?

No. The security standard applies to individual health information that is maintained or transmitted. This is a much broader reach than the specific transactions defined in the law. The electronic signature standard applies only to the transactions adopted under HIPAA.

9. Is the use of an electronic signature mandatory?

No. None of the transactions adopted under HIPAA requires an electronic signature at this time.

10. Do the Security Standards apply to hardcopy, e.g., paper documents, as well as to electronic information?

No. The standards apply to individual health information in electronic form only.

11. Why doesn't the Security Standard select specific technologies to be used?

To select a specific technology to satisfy the security requirements found in HIPAA would tend to bind the health care community to systems and/or software that may soon be superseded by rapidly developing technologies and improvements. The Security Standard was developed with the intent of remaining "technologically neutral" to facilitate adoption of the latest and most promising developments in this dynamic field and to meet the needs of health care entities of different size and complexity. The security standard is a compendium of security requirements that must be satisfied. The particular solution will vary from business to business but each will meet the basic requirements.

12. How could a small provider implement the security standard?

The proposed security standard does not require extraordinary measures to implement. It involves taking actions that a prudent person would agree were necessary to assure the security of the information to be protected. The standard does not dictate specific technologies. The requirements of the standard may be implemented in a number of ways, depending upon the security needs and technologies in place at each business and upon agreements among businesses that work together.

The Notice of Proposed Rule Making includes an example to illustrate the manner in which a small provider might implement the standard. We expect that those required to implement the standard would first assess their security risks and vulnerabilities and the mechanisms currently in place to mitigate those risks and vulnerabilities. Following this assessment, they would determine what additional measures, if any, need to be taken to meet the security requirements.

Frequently Asked Questions About the National Standard Employer Identifier

1. Why is a standard employer identifier needed for electronic health transactions?

Employers, as sponsors of health insurance for their employees, often need to be identified in health care transactions, and a standard identifier for employers would be beneficial for transactions exchanged electronically. Health care providers may need to identify the employer of the participant on claims submitted to health plans electronically. Employers need to identify themselves in electronic transactions when they enroll or disenroll employees in a health plan or make premium payments to health plans on behalf of their employees. Employers and health care providers may need to identify an employer as the source or receiver of information about a participant's eligibility.

2. What standard is being proposed as the employer identifier for use in electronic health transactions?

We are proposing the Employer Identification Number (EIN), the taxpayer identifying number for employers that is assigned by the Internal Revenue Service (IRS). This identifier has nine digits with the first two digits separated by a hyphen, as follows: 00-0000000.

3. Has the IRS agreed to the use of the EIN as the standard employer identifier for use in electronic health transactions?

Yes, on January 16, 1998, the IRS agreed to the use of the EIN as the identifying number for employers in all electronic health care transactions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

4. How does an employer obtain an EIN?

The IRS maintains the process for assigning EINs. An employer obtains an EIN by submitting IRS Form SS-4, Application for Employer Identification Number, to the IRS. Any business that pays wages to one or more employees is required to have an EIN as its taxpayer identifying number. There would be few, if any, employers that would not already have an EIN for taxpayer identifying purposes.

5. Some employers have more than one EIN. Which one should be used for electronic health transactions?

In the Notice of Proposed Rule Making we ask for public comment on whether one of the employer's EINs should be used consistently in electronic health transactions and how that one EIN should be selected.

6. Who is required by HIPAA to use the EIN in electronic health transactions?

HIPAA does not require employers to use the standard employer identifier or standard health care transactions. However, we believe that many employers will want to take advantage of this standardization. Providers, health plans, and health care clearinghouses are required to use the standard employer identifier in electronic transactions, such as health care claims or eligibility inquiries, if the transactions require an employer identifier.

7. How would a provider, health plan, or health care clearinghouse obtain the EIN of an employer for use in electronic health care transactions?

Health care providers, health plans, or health care clearinghouses would obtain an employer's EIN directly from the employer. The proposed rule would require an employer to disclose its EIN, upon request, to any entity that conducts standard electronic transactions that require that employer's identifier. The authority to require this disclosure is implicit in HIPAA's directive to the Secretary to adopt an employer identification number for use in the health care system. We have identified no reason for an employer to refuse to furnish the number. The EIN, unlike the Social Security Number, is not information about a person. EINs are not considered private and they may be freely exchanged by employers and others.

Frequently Asked Questions About the National Provider Identifier

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1. What is the National Provider Identifier (NPI)?

Today, health plans assign identification numbers to health care providers -- individuals, groups, or organizations that provide medical or other health services or supplies. The result is that providers who do business with multiple health plans have multiple identification numbers. The NPI is a unique identification number for health care providers that will be used by all health plans. Health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions specified by the Health Insurance Portability and Accountability Act (HIPAA). The NPI is an eight-position alphanumeric identifier. The eighth position is a check digit that can help detect keying errors. It contains no embedded intelligence; that is, it contains no information about the health care provider such as the type of health care provider or State where the health care provider is located.

2. Who would get an NPI?

NPIs would be given to health care providers that need them to submit claims or conduct other transactions specified by HIPAA. A health care provider is an individual, group, or organization that provides medical or other health services or supplies. This includes physicians and other practitioners, physician/practitioner groups, institutions such as hospitals, laboratories, and nursing homes, organizations such as health maintenance organizations, and suppliers such as pharmacies and medical supply companies. This does not include health industry workers, such as admissions and billing personnel, housekeeping staff, and orderlies, who support the provision of health care but do not provide health care services.

3. How would NPIs be issued?

NPIs would be issued by the National Provider System (NPS) based on information entered into the NPS by one or more organizations known as "enumerators" Enumerators would carry out a number of functions, which include entering identifying information about a health care provider into the system, performing data validation (for example, confirming the State license number), notifying a health care provider of its NPI, and updating information about a health care provider when notified by the health care provider.

4. What entities would be enumerators?

The two most viable options are described below. The Notice of Proposed Rule Making welcomes feedback on these options, as well as on alternate solutions. Because the data needed to enumerate Medicare providers is already available in the Health Care Financing Administration (HCFA) files, that information will be loaded into the NPS and NPIs will be assigned automatically to Medicare providers under either option described below. Medicare providers, therefore, would not have to apply for an NPI.
Option 1: A Federally-directed registry would be the enumerator of all health care providers.

After the initial load of Medicare provider data and assignment of NPIs to Medicare providers, all the remaining health care providers would apply directly to the registry for an NPI. The registry could be operated by an agent or contractor. The registry would enter the provider's data into the NPS; the NPS would assign an NPI, and the registry would notify the provider of the NPI.

Option 2: A combination of Federal programs (health plans), Medicaid State agencies, and a registry would be enumerators.

Federal programs and Medicaid State agencies would enumerate their own health care providers by entering provider data into the NPS; the NPS would assign NPIs to the providers. Each health care provider participating in more than one Federal or Medicaid health plan could choose the one by which it wishes to be enumerated. All other health care providers would apply directly to a Federally-directed registry for an NPI.

5. When will the NPI be used?

Two years after the adoption of this proposed standard, the NPI must be used by health plans, health care clearinghouses, and those health care providers that conduct electronic transactions specified by HIPAA. Small health plans have three years to comply.

6. What are the uses of the NPI?

The NPI must be used in connection with the electronic transactions identified in HIPAA. In addition, the NPI may be used in several other ways:

1. By health care providers to identify themselves in health care transactions identified in HIPAA or on related correspondence;

2. by health care providers to identify other health care providers in health care transactions or on related correspondence;

3. By health care providers on prescriptions (however, the NPI could not replace requirements for the Drug Enforcement Administration number or State license number);

4. By health plans in their internal provider files to process transactions and communicate with health care providers;

5. By health plans to coordinate benefits with other health plans;

6. By health care clearinghouses in their internal files to create and process standard transactions and to communicate with health care providers and health plans;

7. By electronic patient record systems to identify treating health care providers in patient medical records;

8. By the Department of Health and Human Services (HHS) to cross reference health care providers in fraud and abuse files and other program integrity files; and

9. For any other lawful activity requiring individual identification of health care providers, including activities related to the Debt Collection Improvement Act of 1996 and the Balanced Budget Act of 1997.

7. How can a health care provider obtain an NPI?

After the standard is announced in the Final Rule in the Federal Register, the NPS will begin assigning NPIs to health care providers based on information entered by the enumerator(s). Because there are so many providers, HHS recommends in the Notice of Proposed Rule Making that assignment of the NPI be done in phases. Providers who conduct any of the transactions specified in HIPAA would be enumerated before those who do not. Because the data needed to enumerate Medicare providers is already available in HCFA files, that information will be loaded into the NPS and NPIs will be assigned automatically to Medicare providers. As a result, Medicare providers would not have to apply for NPIs.

Frequently Asked Questions About Code Sets

1. What is a code set?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a "code set" is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes.

Medical data code sets that are used in the health care industry include coding systems for: diseases, injuries, impairments, other health related problems, and their manifestations; causes of injury, disease, impairment, or other health-related problems; actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments and any substances, equipment, supplies, or other items used to perform these actions. Code sets for medical data are required for data elements in administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures, and drugs.

2. What code sets are recommended in the Notice of Proposed Rule Making (NPRM)?

The code sets being proposed as initial HIPAA standards are all de facto standards already in use by most health plans, health care clearinghouses, and health care providers. They are:

- ICD-9-CM: The International Classification of Diseases (ICD), Ninth Revision, Clinical Modification (ICD-9-CM), classifies both diagnoses (Volumes 1 & 2) and procedures (Volume 3). All hospitals and ambulatory care settings use this classification to capture diagnoses for administrative transactions. The ICD-9-CM procedure system is used for all inpatient procedure coding for administrative transactions.

- CPT-4: Physician Current Procedural Terminology (CPT) is used by all physicians to code their services for administrative transactions. CPT-4 is level one of the Health Care Financing Administration Procedure Coding System (HCPCS).

- Alpha-numeric HCPCS: Alpha-numeric HCPCS contains codes for medical equipment, injectable drugs, transportation services, and other services not found in CPT-4. Alpha-numeric codes are level 2 of HCPCS. They are used in ambulatory settings.

- CDT-2: Current Dental Terminology (CDT) is used for reporting dental services. CDT-2 codes are also included in alpha-numeric HCPCS with a first digit of D.

- NDC: National Drug Codes (NDC) are used for reporting prescription drugs in pharmacy transactions and some claims by health claim professionals.

3. How will the implementation of national standard code sets reduce burden on the health care industry?

Standardized data content is essential for accurate and efficient electronic data exchange between the many producers and users of administrative health care transactions. Currently, these national codes sets are mandated for use in some Federal and State programs, such as Medicare and Medicaid. The Accredited Standards Committee X12N and National Council for Prescription Drug Programs standards setting organizations have adopted these codes sets for use in their standards.

4. What will be the impact of these standards on the health care industry?

By adopting standards for code sets we are requiring that all parties accept these codes within their electronic transactions. We are not requiring payment for all services for which there are codes. However, when the HIPAA code set standards become effective, all health plans will have to receive and process all standard codes, regardless of reimbursement or coverage policies for certain conditions or procedures. The requirement to use standard coding guidelines will simplify claims submission for health care providers who deal with multiple health plans and improve data quality. Health plans and others that do not follow official coding guidelines today will be required to modify their systems to accept all valid codes in the standard or engage a health care clearinghouse to process the standard transactions for them.

5. Have decisions been made about the introduction of new code set standards (e.g., ICD-10-CM)?

No decisions have been made regarding changes in code set standards. However, it is certain that there will be changes to coding and classification standards because of the international adoption of ICD-10. Therefore, those who produce and process electronic administrative health transactions should anticipate these changes and build in system flexibility to allow them to implement different code set formats within a year following adoption of the initial standards. Any recommendation regarding the implementation of new standards will require a new NPRM.

6. What has been done to eliminate redundancy among some codes sets?

We are proposing modifications to alpha-numeric HCPCS to eliminate overlaps and duplications in three areas:

1. We propose that dental codes be eliminated from HCPCS. The American Dental Association (ADA) has agreed to become the sole source for the authoritative dental code set.

2. We propose that NDC codes become the national standard for all types of transactions requiring drug codes and that "J" codes be deleted from alpha-numeric HCPCS. Therefore, health plans, health care clearinghouses, and health care providers will have to process 11-digit NDC codes as part of the standard electronic transactions. With this change, greater national uniformity can be achieved, the workload of providers who previously had to utilize two drug coding systems will be reduced, and the need for local codes will diminish substantially.

3. We propose that HCPCS Level 3 codes established on a local basis by health insurers be eliminated. These codes have been created when no specific code could be found in Levels 1 or 2. To replace these local codes, we propose that a national process be established to review and approve codes that are needed by any public or private health insurer. This new centralized process for establishing national temporary codes would run parallel to the process for establishing national CPT codes, alpha-numeric HCPCS codes, and NDC codes.

7. Where can I get more information about the code sets?

ICD-9-CM: Official version is available on CD-ROM from the Government Printing Office (GPO) at 202-512-1800 or fax 202-512-2250. The CD-ROM contains the ICD-9-CM classification and coding guidelines. Versions of ICD-9-CM are also available from several not-for-profit and other private sector vendors.

CPT-4: Official version is available from the American Medical Association. Versions are also available from several not-for-profit and other private sector vendors.

Alpha-numeric HCPCS: Official versions of the 1998 alpha-numeric HCPCS files (excluding the D procedure codes copyrighted by the ADA) are available from the HCFA website at http://www.hcfa.gov/stats/pufiles.htm

CDT-2: Official version is available from the American Dental Association, 800-947-4746.

NDC: Official versions of the files are available on the Internet's World Wide Web on the CDER Home Page at http://www.fda.gov/cder/ndc/index.htm. NDC codes are also published in the *Physicians' Desk Reference* under the individual drug product listings and "How supplied." The supplements are available quarterly on diskette from the National Technical Information Service at 703-487-6430.

1. Why are national standards for electronic health care transactions being proposed?

Congress and the health care industry have agreed that standards for the electronic exchange of administrative and financial health care transactions would be a major step toward improving the efficiency and effectiveness of the health care system. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) included provisions that require the Secretary of Health and Human Services to adopt such standards.

National standards will achieve administrative savings and reduce the administrative burden on health care providers and health plans. Today most health care providers and health plans use many different electronic formats, with different data requirements, to exchange claims, remittances, and other transactions. A national standard for electronic transactions means one format. Once the standards are in place, health care providers will be able to submit a standard transaction containing standard content to any health plan and that plan must accept it. In addition, health plans will be able to send standard transactions (e.g., remittance advices) to health care providers. National standards will make electronic data interchange a viable alternative over paper processing.

2. What transactions are covered by these proposed rules?

Under HIPAA, the Secretary of Health and Human Services is proposing standards for the following administrative and financial health care transactions:

Health claims or equivalent encounter information.
Enrollment and disenrollment in a health plan.
Eligibility for a health plan.
Health care payment and remittance advice.
Health plan premium payments.
Health claim status.
Referral certification and authorization.
Coordination of benefits.

Standards for the first report of injury and claims attachments (also covered by HIPAA) will be proposed at a later date.

3. Are these government standards that are being adopted?

HIPAA requires that the Secretary adopt standards, when available, from private sector, ANSI-accredited standards development organizations (SDOs), not from government. All but one standard transaction comes from the Accredited Standards Committee (ASC) X12N. The standard for the retail pharmacy claim comes from the National Council for Prescription Drug Programs (NCPDP), which is also an accredited SDO.

4. Who is affected by these standards?

All health plans (including Medicare and State Medicaid programs), all health care clearinghouses, and any health care provider that chooses to submit transactions electronically are affected. These entities must comply with the standards when conducting any of the transactions covered by HIPAA with another entity outside their corporate boundaries. Transmissions within a corporate entity are not required to comply with the standards.

A health care clearinghouse may accept nonstandard transactions for the sole purpose of translating them into standard transactions for sending customers and may accept standard transactions and translate them into nonstandard transactions for receiving customers.

5. What is the effect on State law?

Standards for these transactions will supersede any State law that is contrary to them, unless the Secretary grants a waiver. A process for requesting a waiver is described in the Notice of Proposed Rule Making. State Medicaid programs are health plans under the law and will be required to comply with the standards.

6. When will the standards become effective?

All health plans, all health care clearinghouses and any health care provider that chooses to transmit any of the transactions in electronic form must comply within 24 months after adoption of the standard (36 months for small health plans). The 24-month transition period will not be shortened by delays in adoption of the standards.

7. How will the standards be enforced?

The law gives the Secretary authority to impose penalties up to $100 per violation on anyone who fails to comply with a standard. The total monetary penalty on one person per year may not exceed $25,000 per violation of each requirement. A workgroup has been formed to address monitoring and enforcement issues. Recommendations on monitoring and enforcement will be published at a later date.

8. How were the standards chosen?

As required by HIPAA, the Secretary consulted with the National Uniform Claim Committee (NUCC), the National Uniform Billing Committee (NUBC), the American Dental Association, and the Workgroup for Electronic Data Interchange (WEDI). The Secretary also received and considered advice from the National Committee on Vital and Health Statistics (NCVHS) and representatives of the health care industry who testified before the NCVHS Subcommittee on Health Data Needs, Standards, and Security.

There was overwhelming support for X12N standards for all the transactions except health care claims. The consensus choice for the retail pharmacy claim was the standard maintained by the NCPDP because it is already in widespread use. Some organizations favored standards other than X12N for the professional and institutional claim standards. However, even those favoring other standards wanted to migrate to the X12N claim format eventually.

After taking into account all of the advice, the Secretary decided to recommend adoption of X12N standards for all but the retail pharmacy claim. The X12N and NCPDP standards met all the criteria developed to measure a standard's suitability.

9. Where can I obtain implementation guides and data dictionaries for the standards?

Specific, millennium compliant versions of each standard will be adopted. In addition to information contained in the Notice of Proposed Rule Making, each transaction standard will have detailed implementation guides, data dictionaries, and unambiguous data conditions.

Copies of X12N implementation guides can be downloaded from the Washington Publishing Company web site at http://www.wpc-edi.com/hipaa/ or contact Washington Publishing at 301-590-9337 to purchase a printed copy. Information about obtaining the implementation guide for the NCPDP standard is available from their web site at http://www.ncpdp.org.

10. How can I recommend changes to the standards?

For now, changes can be recommended through the NPRM comment process. Once the standards have been finalized, there will be a process established for maintenance. The Final Rule will describe this process.

Milestones in Health Information Standards

August 21, 1996	Health Insurance Portability and Accountability Act (HIPAA) becomes law
October 1996	Implementation begins
July 9, 1997	Public Forum on Progress Toward Administrative Simplification
October 1997, updated May 1999	HIPAA Implementation Guides and Data Dictionaries available for ANSI X12N Transaction Standards. Download free.
July 20-21, 1998 in Chicago	Hearings on the Individual Identifier held by the National Committee on Vital and Health Statistics. HHS prepared a White Paper as background information for these hearings. Reaction to discussion of individual identifier in absence of privacy protection prompted administration to put this standard development on hold.

Tentative Schedule for Publication of HIPAA Administrative Simplification Regulations

The Department of Health and Human Services is planning to issue HIPAA regulations under the following schedule. The amount of time from publication of the Notice of Proposed Rule Making (NPRM) to publication of the final rule is needed to review and respond to the large number of comments received on the NPRMs. (For example, we received over 17,000 comments on the Transactions and Coding NPRM alone). Both the logistics of handling that many comments, and the analysis of the issues raised impact on the time it is taking to develop the final rule. In addition, these rules need to be reviewed not only within the Department of Health and Human Services and a number of its subordinate agencies, but also with several other Federal departments affected by the rules.

This schedule is, of course, subject to change due to a number of circumstances.

NPRMs Already Published:

Standard	PRM Published	Expected Final Rule Publication	Expected Date Compliance Required*
Transactions and Coding	5/07/98	11/99	2/2002
National Provider Identifier	5/07/98	12/99	7/2002
National Employer Identifier	6/16/98	12/99	3/2002
Security	8/12/98	12/99	3/2002

NPRMs in Development:

Standard	Expected NPRM Publication	Expected Final Rule Publication	Expected Date Compliance Required*
National Health Plan Identifier	12/99	5/2001	7/2003
Claims Attachments	9/99	9/2000	11/2002
National Individual Identifier	(On hold pending privacy legislation and/or regulations)		

** Standards are required to be implemented within two years of the effective date of the final rule; generally 60 days after publication of the rule. However, the effective date for the National Provider Identifier is planned to be no earlier than 7/2000, to give the Department enough time to develop the system for implementing the identifier.*

Last updated 5/10/99.

ATTACHMENT 24

Sources for Initial Database of Potential Eligibles

- **MA claims databases:**
  - MH/AODA and targeted case management claims data for CY 1996 only, for all medical status codes; some service-intensity proxies used to eliminate lowest intensity.
  - Data file using Ambulatory Care Groups (ACG) & Disability Payment System (DPS) health status groupers to identify MH and/or AODA service users, for CYs 95, 96, & 97, but only for SSI-related medical status codes.
  - Preadmission Screening and Annual Resident Review (PASARR) data for CYs 96, & 97. Note: PASARR screening requirements changed in 1997 which reduced the number of screenings done.
  - Claims data file for CYs 95, 96, & 97, for all medical status codes, using only service-intensity proxies (CSP, in-home psychotherapy, autism treatment, TCM, and day treatment; but not inpatient hospital psychiatric treatment).
- **Human Services System Reporting System (HSRS) databases**
  - HSRS Core data elements for CYs 95, 96, & 97.
  - HSRS MH Module data elements only for CY 97; no data from Dane Co. and problematic data from Milwaukee Co.
  - MH population defined in HSRS data by target group code, client characteristics, and presence in MH Module. Some undercounting likely for kids, because non-MH client characteristics (& target group codes) often used for kids with MH problems (e.g., child welfare or juvenile justice codes, etc.)

ATTACHMENT 25

Instructions for Consumer Data Feedback from Counties

This attachment is excepted from a September 1998 letter to the rate-setting work group.

Overview

There are two parts to your task in providing feedback on the consumer lists we have provided to you:

1. Indicate for each person on the list that the person:

    - Does fit the target population and, if so, whether the person has a co-occurring disability; or,

    - Does not fit the target population; or,

    - Is unknown to you.

2. For each person who does fit the target population, indicate their severity level using the HSRS severity codes.

The state data files you have received list MH consumers of all ages, and some of the persons listed may not fit within the target populations in your county's RFLI proposal. We ask that you please attempt to verify and code all the individuals listed for your county, regardless of the consumer's age or target population. If all the partner counties can provide information on all age groups and on the broadest possible target population, then we will be better able to identify persons to potentially be served under the demonstrations, and consequently do a better job of MA rate-setting.

In addition, we want to identify non-MA eligible members of the target population (primarily through HSRS data, at this point), because some of them could become MA-eligible, for a number of reasons. Furthermore, this small group needs to begin investigating different ways to estimate non-MA utilization and costs for the MH and AODA target populations (e.g., through CARS & HSRS, through county databases, etc.). This would include county services provided to non-MA-eligible persons and county services not billed or not billable to MA for MA-eligible persons.

Lastly, the state data files list consumers that have been unduplicated within each of three calendar years: 1995, 1996, and 1997. However, individuals have not been unduplicated between calendar years, so a person may show up in more than one year, and that is important information to know, especially in regard to length and periodicity of illness and length of treatment. Therefore, please match each consumer listed in the state data files against your county records for each of the three calendar years. Don't just stop if you find the person in any one year — please check all three years.

Target Population

There is a column labeled "**CVERF**" in the state data files (in both the MA data that was previously distributed and the additional HSRS data files). This is the column where each partner county (or multi-county group) provides feedback on whether they think each individual listed for their county(ies) falls within the MH target population for the MH/AODA Managed Care Demonstrations. **For this rate-setting analysis, the MH target population is defined as BRC Target Groups 1, 2, and 3**. As stated earlier in these instructions, only BRC Target Groups 1 and 2 will be included in the prepaid managed care part of the demonstrations, while BRC Target Groups 3, 4, and 5 will receive coordinated care through a non-managed-care, resource-center-like component of the demonstrations. However, for this analysis we want to capture data for BRC Target Group 3 in order to estimate the size and costs of that population, even though its services will not be funded through prepaid managed care.

There will be some persons with AODA and MH dual-diagnoses in the state MH data files. Please evaluate whether these dually diagnosed individuals fit the target groups based on their MH needs only. We will address the AODA aspects of these and other AODA/MH dually-diagnosed persons in a later phase of this consumer data feedback. We also need to identify persons with other types of dual-diagnoses besides MH and AODA, because the boundaries between LTC-R and the MH/AODA Managed Care demonstrations have not yet been determined. This dual-diagnosis information will be important for on-going discussions on which consumers will receive which services through which system.

There are nine possible single-character responses for this "**CVERF**" column — N, Y, A, D, B, E, P, R, and U. (There is only room in this column for a single-character.) Here are the descriptions of those nine responses:

- An "**N**" (for No) response means the county thinks the individual does not fit within MH BRC Target Groups 1, 2, or 3.

- A "Y" (for Yes) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, without any sort of dual diagnosis.

- An "A" (for AODA) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, and the persons has an AODA and MH dual diagnosis.

- A "D" (for Developmental Disability, or DD) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, and the persons has a DD and MH dual diagnosis.

- A "B" (for Traumatic Brain Injury, or TBI) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, and the persons has a TBI and MH dual diagnosis.

- An "E" (for Elderly/Aging) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, and the persons has an Elderly/Aging and MH dual diagnosis.

- An "P" (for Physical Disability, or PD) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, and the persons has a PD and MH dual diagnosis.

- An "R" (for Non-Resident) response means the county thinks the individual does fit within MH BRC Target Groups 1, 2, or 3, but the individual is not a resident of the county and the county is not fiscally responsible for that individual. (There are certain circumstances in the MA data system where a person may receive a county code based on where they receive inpatient treatment rather than their home address. It is important to identify and reassign costs for these persons when doing county-specific rate-setting.) If you are uncertain about fiscal responsibility for an individual because of inter-county agreements to cover service costs for each other's residents, then please contact Bruce Wasserstrom to discuss the case.

- A "U" (for Unknown) response means the individual is unknown to the county, and therefore the county cannot determine whether the individual fits within MH BRC Target Groups 1, 2, or 3.

When comparing the state and county records, you may find individuals in your own data bases who fit within MH BRC Target Groups 1, 2, or 3, but who do not show up in either the MA or HSRS data files from the state. This may occur more in regard to the MA data for CY 1997 consumers, and more in regard to the HSRS data for children in any of the three years. If you do find such missing persons, then please report these individuals in a separate document or file, including their full name, date of birth, and Social Security Number (or MA ID number). As we test the ability to use state data sources for rate-setting for these MH/AODA demonstrations, it's important to find out if, and to what extent, the state data bases are incomplete.

Severity Scoring

A. MH and AODA Severity Definitions

Each partner county is also supposed to provide feedback on the severity of the MH problems for each individual listed in the state data files for their county. One purpose of this severity-level scoring by the partner counties is to judge the accuracy of state data-analysis methods for identifying severity levels in the target population. For example, how well do the severity indicators produced by the ACG and DPS health grouper software match up with the severity scores from the partner counties, who know the individual consumers (more) directly? Another use for this severity scoring could be for the development of rate-bands (rate tiers), if it is decided that the target population needs to be segmented by costs.

The various components of the mental health target population for the demonstrations are defined by different severity-of-need levels (*see the Target Population section above*). This overlap between target population definitions and severity-level scoring definitions

was the source of much confusion at the July 28th Rate-Setting/County-Share Small Group meeting, and as a result, there was only a murky, partial consensus on how the severity scoring levels should be defined. After additional discussion among the DHFS staff, some clarity emerged. For this rate-setting analysis, we will use the intensity (or "severity") of **services delivered** as a proxy for a person's actual severity of need. There are several reasons for defining MH/AODA severity in terms of services delivered for this consumer data feedback:

- There is clearly a gap between MH/AODA services needs and the services actually delivered for many individuals in Wisconsin's public sector MH/AODA system. However, unmet service needs is a big enough topic that it will have to be addressed separately from this current rate-setting analysis to make sure that the issue doesn't get lost and to do justice to its complexity.

- Most of the partner counties represented at the July meeting seemed to prefer using services delivered as a proxy for severity, because it was a more feasible way to check their own records. As I understood it, the representatives from these counties said it would be much easier to find out what services an individual received during a given year and judge severity on that basis, because the service information is available in their county information systems. In contrast, it would require tracking down assessment documents and/or the staff who did the assessments to determine the true service needs of each individual listed in the state data files.

- Verifying a cohort of MA-eligible individuals in the target population is one step in the rate setting process for this MH/AODA managed care project. Rate-setting involves predicting the cost of future services based on an historical pattern of services actually delivered, so it is at least consistent to use services delivered as the basis for scaling the severity of MH and AODA problems in this population. However, we know that we may need to adjust the rate setting process later to account for unmet service needs.

At the July 1998 meeting, the Small Group did decide to rank four levels of severity, but the group did not have a clear consensus on how those four levels should be defined. The two most popular suggestions were:

- The four severity codes used in the HSRS Mental Health Module:

    1. Persons in Need of Ongoing Comprehensive Services
    2. Persons in Need of Periodic Intensive Services
    3. Persons in Need of Ongoing Low Intensive Services
    4. Persons Needing Short Term Situational Services

- Four subjectively defined levels of service intensity (or "severity"): High, Medium, Low, and (short-term) Situational.

We will use the four severity codes from HSRS MH Module as the severity scale for partner county feedback.

It is important to remember that for purposes of this rate-setting analysis, the MH target population is defined as BRC Target Groups 1, 2, and 3, and those three BRC Target Groups correspond to the four HSRS MH Module severity codes approximately as follows.

- BRC Target Group 1 = MH Module Severity Code 1
- BRC Target Group 2 = MH Module Severity Codes 2 and 3
- BRC Target Group 3 = MH Module Severity Code 4

Some key reasons for using the HSRS MH Module severity codes are that:

1. They are more clearly defined;

2. Counties are already familiar with them from HSRS reporting; and

3 There are obvious benefits from using consistent definitions across different state databases.

There is still some concern, however, about how to operationally define "periodic," especially because the severity scoring will be based on services delivered instead of services needed. The partner counties are supposed to assign a severity score for each of three calendar years for every individual listed, based on the intensity ("severity") of the services that person received during each of those calendar years. However, the service-delivery record may not distinguish very well between consumers with periodic versus steady-state service needs. This problem is compounded if the periodic cycle of a given individual's MH or AODA service needs lasts longer than one year. How do we know which part of the person's service-need cycle is captured in any of the calendar years we are examining? It may be that these problems with defining and capturing periodicity will average out over the target population, with different individuals being observed in different parts of their periodic service-need cycles. Nevertheless, this small group needs to further explore how to account for the length of these periodic cycles, the consistency of cycle frequency, and the relative intensity at different parts of the cycles. To that end, please contact Bruce Wasserstrom if you or your clinician colleagues have any information to share about periodic cycles of MH/AODA service needs. Also, be prepared to discuss examples you have found where it is difficult to distinguish "periodic" from "on-going" needs when we meet next week.

As a final note on severity, we will also further explore how other states (e.g., Indiana and Michigan) have dealt with MH/AODA severity-level scoring.

B. MH and AODA Severity Coding by the Partner Counties

There is a column labeled "**CSEV**" in the state data files (in both the MA data that was previously distributed and the additional HSRS data files). This is the column where each partner county (or multi-county group) will indicate a MH/AODA severity score for each individual listed for their county(ies) in calendar years 1995, 96, and 97. There are four possible single-character responses for this "CSEV" column — 1, 2, 3, or 4 — representing the four HSRS MH Module severity codes listed below, and described fully in the attached HSRS Manual excerpt.

- A "**1**" response means the county thinks the individual fits HSRS MH Module Severity Code 1: Persons in Need of **Ongoing Comprehensive Services**

- A "**2**" response means the county thinks the individual fits HSRS MH Module Severity Code 2: Persons in Need of **Periodic Intensive Services**

- A "**3**" response means the county thinks the individual fits HSRS MH Module Severity Code 3: Persons in Need of **Ongoing Low-Intensive Services**

- A "**4**" response means the county thinks the individual fits HSRS MH Module Severity Code 4: Persons in Need of **Short Term Situational Services**

As described earlier in these instructions, the state MH data files will include some individuals with AODA and MH dual-diagnoses. The state data files will also list persons with other types of MH dual diagnoses (*see earlier section on "Coding MH Target Population Verification"*). Please evaluate the MH severity of these dually-diagnosed individuals based only on their MH service needs (i.e., MH services delivered, as operationally defined here). We will score the AODA severity of these and other dually-diagnosed persons in a later phase of consumer data feedback.

ATTACHMENT 26

Proxies Used to Assign "Unknowns"

1. Received any of the following services:

   - Community Support Programs
   - Targeted Case Management
   - Intensive In-home Psychotherapy
   - Child/Adolescent Day Treatment

2. Received any of the following drugs:

No.	Therapeu-tic Class Code	Drug Generic Name	Drug Trade (Brand) Name
1	H2GA	Chlorpromazine	Thorazine
2	H2GB	Promazine	Sparine
3	H2GC	Triflupromazine	Vesprin
4	H2GD	Fluphenazine	Prolixin
5	H2GE	Perphenazine	Trilafon, Etrafon
6	H2GG	Trifluoperazine	Stelazine
7	H2GH	Thioridazine	Mellaril
8	H2GR	Mesoridazine	Serentil
9	H2LA	Chlorprothixene	Taractan
10	H2LG	Pimozide	Orap
11	H2LH	Haloperidol	Haldol
12	H2LJ	Risperidone	Risperdal
13	H2LN	Loxapine	Loxitane
14	H2LQ	Butaperazine	?
15	H2LR	Molindone	Moban
16	H2LS	Clozapine	Clozaril
17	H2LT	Thiothixene	Navane
18	H2MA	Lithium	(same as generic?)
19	H2LS ?	Zyprexa	Olanzapine
20	H2LS ?	Seroquel	Quetiapine

ATTACHMENT 27

Specifications for Selecting Proxy Group for Non-Partner County Data

- **Data Elements to Specify or Limit:**

  - **HSRS MH Severity Codes (from MH Module)= 1, 2, and 3 only**. These correspond to MH-BRC Target Groups 1 and 2.

  - **Time Period= CYs 1997** and **1998**.

  - **All counties and tribes**.

- **Data Elements to Report in Data File**:

  - **Full Name of client, with separate fields for the last name, first name and middle name (or initial).**

  - **Date of Birth.**

  - **Social Security Number or MA ID Number. Exclude records where this field is blank, or has all 0's, or has all 9's, or has less than nine digits.**

  - **County of Residence. More than one type of HSRS county code will probably need to be reported.**

    - HSRS county code

    - The HSRS Agency ID Codes

  - **HSRS Severity Code**

  - **HSRS Episode Start & End Dates**

  - **Diagnosis ("Diagnostic Impression")**:

  - **Standard Program Category (SPC) Code**:

ATTACHMENT 28

Phases of Moving Towards Capitation

Phase	Activities	When
1	➢ MCO development activities. ➢ Implement recovery and consumer and family involvement recommendations. ➢ Screening to identify individuals eligible for enrollment. ➢ Data analysis: Medicaid and non-Medicaid. ➢ Optimize Medicaid billing.	18 months following receipt of start-up funds: 7/00 – 12/01 for first two sites; 1/01 – 6/02 for second two sites.
2	➢ Capitate Medicaid for BRC target populations 1 and 2 (and perhaps other groups). ➢ Implement remainder of contract requirements. ➢ Collect and report non-Medicaid utilization and expenditures. ➢ Evaluate client and system outcomes (including fiscal).	Two years: 1/02 -- 12/03 for first two sites; 7/02 – 6/04 for second two sites.
2.5	➢ Begin work with new sites, if authorized by 01-03 budget.	CY02
3	➢ Capitate community aids for BRC 1 and 2. ➢ Prepare for competitive procurement.	CY04-05
4	➢ Expand capitation to include other groups (e.g., BRC 3, substance abuse only). ➢ Possible eligibility waivers for SA populations, kids with SED.	? Possibly overlapping phase 3, depending upon adequacy of data.
5	➢ Competitive procurement for initial sites	CY06

ATTACHMENT 29

Letter Of Intent

Future correspondence regarding the MH/AODA managed care request for consideration (RFC) will be sent only to counties/tribes returning a letter of intent. This includes, but is not limited to, written responses to questions from the proposers conference and amendments to the RFC.

Returning this letter of intent does not obligate the county/tribe to submit a proposal in response to this RFC.

County/Tribe Name(s): _____

_____

Name, Title and Address of County/Tribal Official Who Should Receive Future Correspondence

_____

_____

_____

_____

_____

Proposed managed care model (check one)

☐ Carve-out (MH/AODA only)
☐ Carve-in (all Medicaid-covered services)

Proposed age groups (check all that apply)

☐ 0-17
☐ 18-64
☐ 65+

Please return this form by March 9, 2000, to:

Shel Gross, MH/AODA Managed Care Policy Analyst
Division of Health Care Financing, Rm. 237
P.O. Box 309
Madison, WI 53701-0309

ATTACHMENT 30

Commitment to Participate Agreement

The county(ies)/tribe(s) of _____, if selected as a MH/AODA managed care demonstration project, or alternate, agree(s) to:

1. Provide staff to the demonstration project according to the specifications contained in the RFC.

2. Participate in workgroups, meetings and technical assistance sessions, organized or designated by the Department, to assess progress, capture organizational learning, and further the implementation of the MH/AODA managed care demonstration. This participation may include a multi-day MIS workshop, and approximately 2-4 days per month for other activities;

3. Share information about best practice and other operational lessons with the other MH/AODA managed care demonstration projects, through a process established jointly by the Department and the demonstration sites;

4. Participate in special studies initiated by the Department on topics such as studies of enrollment and disenrollment processes; documentation of assessment, case plan and service delivery; achievement of consumer outcomes, etc.;

5. Share materials and reports with Department staff, as requested. This could include financial reports, audits, position descriptions, service delivery policies, Quality Assurance/Improvement plans and reports, etc., as well as narrative progress reports;

6. Participate in site visits by Department-designated staff to the demonstration project site; and

7. Upon Department request, participate in the submission of a federal waiver for future expansion of the demonstration projects.

Signature of official authorized to sign for each county/tribe	county/tribe	date
Signature of official authorized to sign for each county/tribe	county/tribe	date
Signature of official authorized to sign for each county/tribe	county/tribe	date
Signature of official authorized to sign for each county/tribe	county/tribe	date

ATTACHMENT 31

Application Summary Form

Proposers: List all counties/tribes that are included in proposed program.

_____

_____

Contact: List a single, lead contact person.

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

E-mail:_____

Proposal Type: Check one.

☐ MH/AODA only

☐ MH/AODA and primary and acute care

Name of HMO partner _____

Ages Included: Check all that apply.

☐ children ☐ adults ☐ elderly

Medicaid Populations Included: Check all that apply.

☐ SSI ☐ foster care ☐ dual entitlees (Medicaid/Medicare)

☐ AFDC ☐ nursing home

☐ others: list _____

ATTACHMENT 32

Personnel of the Demonstration Project

Title & Role in the Project	% of Time	Name	Qualifications

Note: **If necessary, duplicate for extra forms or create the same form in your computer. This form is not included in your page limit.**

ATTACHMENT 33

Provider Contracts

Instructions:

1) Service type is defined as the services in the benefit package in Attachments 10 and 17. List out alphabetically by services.

2) Use 1998 data.

Service Type	Provider Name(s)	Number of clients served in 1998	Amount spent in 1998 purchasing services for these clients

Note: **If necessary, duplicate for extra forms or create the same form in your computer. This form is not included in your page limit.**

ATTACHMENT 34

Workplan

Task	**Lead staff**	**Timeframe**

Note: **If necessary, duplicate for extra forms or create the same form in your computer. This form is not included in your page limit.**

ATTACHMENT 35

Detailed Budget Request Form
For First Year Commencing with Receipt of Start-Up Funds

Organization: _____	**Phone:_____**
Address: _____	**Date:_____**
City & State:_____	**Fax: _____**
	Authorized Signature:_____

1. Demonstration Project Personnel

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Title of Position	% of Time Budgeted	Hr. Rate or Mo. Salary	Hours Per Week	# Mos. Budgeted	Annual Cost	In-Kind Contribution	Funds Requested
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		$			$	$	$
		(i) Personnel Total Salary			$	$	$

Separate Sheet Attached: • **Yes** • **No**

Detailed Budget Request Form I, Page 2

	Amount Budgeted	In-Kind Contribution	Funds Requested
2. Fringe Benefits for Program Personnel _____ % (Employer FICA: Employee Insurance)	$	**$**	**$**
3. Agency Personal Liability Insurance (Professional Staff)	$	$	$
4. Travel Expenses a. Professional Staff b. Volunteer Workers	$	$	$
5. Total Equipment Expenses (attach separate sheet detailing)	$	$	$
Total Supplies and Operating Expenses (attach separate sheet detailing)	$	$	$
7. Total Contractual & Consultant Costs (attach separate sheet detailing)	$	$	$
8. Training for Paid and Volunteer Workers: a. Initial Training b. Inservice Training	$	$	$
9. Advertising Costs	$	$	$
10. Total Other Expenses (attach separate sheet detailing)	$	$	$
11. Grand Total (Lines 2 through 10, plus **(g)** from Page 1)	$	$	$

Note: Provide budget detail on separate sheets for *(4) Travel, (5) Equipment, (6) Supplies and Operating Expenses, (7) Contractual and Consultant Costs, and (10) Other Expenses.*

ATTACHMENT 36

Assurances of Compliance with
Department of Health and Family Services Regulations

(Completion of this form is consistent with the intent of Title VI, Civil Right Act & 45 CFR Part 80)

_____ (Name of Applicant) (hereinafter called the "Applicant")
HEREBY AGREES THAT it will comply with the following assurances:

The undersigned possesses legal authority and capacity to enter into this contract and a motion has been duly passed as an official act of the governing body of the application, authorizing the execution of this agreement, including all understandings and all assurances contained therein, and authorizing the person identified as the official representative for the Applicant to act in connection with the Applicant and to provide such additional information as may be required.

The Applicant agrees that (a) funds granted as a result of this request are to be expended for the purposes set forth in this application and in accordance with all applicable laws, regulations, policies and procedures of the State of Wisconsin or the Federal Funding Agency, as applicable; (b) no expenditures will be eligible for inclusion if occurring prior to the effective date of the grant; funds awarded by the Wisconsin Department of Health and Family Services may be terminated at any time for violation of any terms and requirements of this agreement.

The Applicant ensures compliance with the Title VI of the Civil Rights Act of 1964 (P.L. 88-342), and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 CRF Part 80) issued pursuant to that title. To that end, and in accordance with Title VI of that act and the regulations, no person in the United States shall, on the grounds of race, color or national origin, be excluded from participating in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity in which the designated agency received federal assistance, or financial assistance from the Department; and **HEREBY GIVES ASSURANCE THAT** it will immediately take any measures necessary to effectuate this agreement.

The Applicant ensures compliance with Title IX of the Education Amendment of 1972 which state that no person in the United States shall, on the basis of sex, be excluded from participating in, be denied the benefit of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives or benefits from Federal financial assistance.

The Applicant shall comply with Section 504, Rehabilitation Act of 1973 which prohibits discrimination on the basis of a physical condition or handicap and the Age Discrimination Act of 1975 which prohibits discrimination because of age.

The Applicant shall ensure the establishment of safeguards to prevent employees, consultants, or members of governing bodies from using their position for purpose that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties as specified in Wisconsin Statutes 946.10 and 946.13.

Date_____, 19_____ Applicant _____

By _____

ATTACHMENT 37

Changes from Draft RFC

The following represent the more substantive changes from the draft RFC. Other changes have been made to clarify language from draft.

RFC Category	Change
III. A. 1 & 2	Add language describing implications of initial FFS option.
III. A. 6	New section added to address relationship to Family Care. Consumer would be able to choose if they meet the eligibility for both.
III. A. 7	New section added to address relationship to other Medicaid managed care programs.
III. C.	All sites are required to meet goals of increased consumer and family access to services and better information, assistance and support to consumers and families.
III. D. 1	Individuals will not be enrolled during a crisis. Capitation not retroactive. Crisis services would be funded as they are now (part of non-capitated system). Crisis services for persons already enrolled would be funded from capitated funds.
III. D. 2	Just cause disenrollment defined.
III. D. 3. a	CSP is a required service option because all Medicaid-covered services must be available. CSP may be an option as a service coordination agency.
III. D. 3. b	Capitation starts with enrollment.
III. D. 3. c	Language added to clarify that decision-making is team driven with mechanisms to ensure strong consumer/family voice and that service coordinator is empowered to make certain decisions for MCO.
III. D. 3. c. (2)	Change of providers without cause allowed one time per year. More changes may occur with cause.
III. D. 3. C.(3)	MCO not obligated to pay for independent housing.
III. D. 3. C. (5)	Information should be provided about the consumer's illness.
III. D. 3. C. (6)	Second consultation process further delineated.
III. D. 3. C. (7)	Section on self-directed care removed.
III. D. 3. C.	People should continue to have choice, as allowed, if under court order.
III. D. 5. A and b	Treatment and recovery plan does not need psychiatrist or psychologist signature, but prescriptions for individual services may require this based on current Medicaid or state regulations.

RFC Category	Change
III. D. 5. f	Denials of Category C services will not be subject to appeal through fair hearing.
III. E. 2	Additional means of involving consumers and families in QI process identified.
III. E. 4	Changed to make somewhat less prescriptive.
III. G. 3	DHFS will provide technical assistance on developing practice standards.
III. H. 1. a	Solvency protection language changed to conform with Family Care.
III. H. 2. a	In addition to tracking MA dollars, should also track non-MA dollars.
IV	Amount of funding available and uses of funds modified.
V.	Significant modifications from draft based on further fiscal analysis.
VI	Modifications to timeline to reflect delay in release of RFC and change in implementation process.
VII.B	Change in language about future competition options.
VIII.	Some changes throughout section.
IX. C.	Negotiations may change the RFC requirements, which would change the contractual obligations.
IX. H.	Background checks requirements supercede non-discrimination.
Atta. 10	Autism treatment services removed from list of Category A services.

ADDENDUM 1

Actuarial Report

This is not available electronically. Please contact:

Shel Gross
Division of Health Care Financing, Rm 237
PO Box 309
Madison, WI 53701-0309
Phone: 608-266-8473
Fax: 608-261-7792
Email: grosss@dhfs.state.wi.us

ADDENDUM 2

This is not available electronically. Please contact:

Shel Gross
Division of Health Care Financing, Rm 237
PO Box 309
Madison, WI 53701-0309
Phone: 608-266-8473
Fax: 608-261-7792
Email: grosss@dhfs.state.wi.us